Gasior Declaration

Exhibit 13

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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ANGIE CRUZ, I.H., AR'ES KPAKA, and RIYA CHRISTIE, on behalf of themselves and all others similarly situated,

Plaintiffs,

vs. No. 14-CV-4456(JSR)(GWG)

HOWARD ZUCKER, as Commissioner of the New York State Department of Health,

Defendant.

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DEPOSITION OF JACK DRESCHER, M.D.

New York, New York

Tuesday, August 11, 2015

Reported by:
Diane Buchanan

August 11, 2015
9:37 a.m.

Deposition of JACK DRESCHER, M.D., held at the offices of State of New York Office of the Attorney General, 120 Broadway, New York, New York, pursuant to Notice, before Diane Buchanan, a Notary Public of the State of New York.

A P P E A R A N C E S:

THE LEGAL AID SOCIETY
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A P P E A R A N C E S:

STATE OF NEW YORK OFFICE OF THE ATTORNEY GENERAL ERIC T. SCHNEIDERMAN
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BY: JOHN GASIOR, ESQ.
ZOEY S. CHENITZ, ESQ.

IT IS HEREBY STIPULATED AND AGREED, by and between the attorneys for the respective parties herein, that filing and sealing be and the same are hereby waived.

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the question, shall be reserved to the time of the trial.

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be sworn to and signed before any officer authorized to administer an oath, with the same force and effect as if signed and sworn to before the Court.

J. Drescher, M.D.

J A C K D R E S C H E R, M.D., called as a witness, having been duly sworn by a Notary Public, was examined and testified as follows:

EXAMINATION BY

MR. GASIOR:

Q. Would you state your name and address.

A. Jack Drescher, M.D., 440 West 24th Street, New York, New York 10011.

Q. Good morning. I'm John Gasior. I'm an Assistant Attorney General for the State of New York, counsel for Defendant in this action.

Will you state your name for the record.

A. Jack Drescher.

Q. Good morning. Is it Dr. Drescher?

A. Yes, Dr. Drescher.

Q. Good morning. I'm going to be asking you a series of questions today regarding an expert opinion that you offered in this proceeding. This proceeding is a case pending in the Southern District of

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New York, a federal court case. If at any time you don't understand one of my questions today, please let me know that you don't understand it and I will try to rephrase it or, perhaps, we can have the court reporter read it back.

If I at some point start dropping my voice today, we have quite a distance between us here today, if you don't hear me, let me know. I will try to pick my voice back up. I would ask you to keep your voice level up because the court reporter is taking a transcript of what you say and so she needs to be able to hear you, number one. But she also needs to hear you, so she can't hear like a nod of the head or shake of the head. So if you give any answers, please make sure to make them verbally and not with a gesture of your head.

Can we do that today?

A. Yes.

Q. Please in that respect, please wait until I finish asking my question. If you start talking at the same time -- you may

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understand where I'm going with the question or think you do at some point and if we start talking over each other, it makes it more difficult for our court reporter, Diane, to take down what we are saying. I will try to do the same for you. I will try not to talk over you, and if you do the same for me, that would make our court reporter's task much easier.

Can we both do that?

A. Yes.

Q. Your testimony today is under oath, it's as if you were in a court of law; do you understand that?

A. Yes.

Q. Is there any medical reason why you can't proceed today to give testimony that's sworn under oath?

A. No.

Q. Are you taking medication that might impair your memory or ability to testify truthfully?

A. No.

Q. Have you ever been deposed before?

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A. Yes.

Q. How many times have you been deposed?

A. Just once.

Q. And what was the case in which you were deposed?

A. It was a class action lawsuit in California against eHarmony.com and I was an expert witness for the plaintiff.

Q. EHarmony. What was the nature of the case?

A. Yes.

Q. What was the nature of that case?

A. They were not permitting gay people to meet each other on the dating website and in California the argument was that was discriminatory. And so the plaintiffs were suing for the right to use eHarmony services and find eHarmony in violation.

Q. What year was that?

A. I think it was 2009.

Q. What was the nature of your involvement there; why were you giving testimony?

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A. I was called to give testimony by the attorneys for the plaintiff. There had been several suits against eHarmony and several years earlier I had been interviewed by USA Today about what I thought of their policies. That's how the attorneys found me. They thought I might have expertise in helping them make their arguments.

Q. Other than the eHarmony litigation, have you given testimony before in an administrative body of any kind?

A. No.

Q. How about testimony before a legislative body?

A. I have been invited to give testimony in New Jersey about a law that they were planning to pass. I think it was an assembly. The assembly in New Jersey passed a law banning conversion therapy. This was before the passing of the law and I was asked to give testimony before that assembly.

Q. Do you recall what year that was?

A. Roughly two or three years ago.

Q. Any other sworn testimony in either

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a court of law, administrative hearing?

A. No.

Q. Did you meet with any attorneys to prepare for your deposition today?

A. Yes.

Q. With whom did you meet?

A. I met with the two attorneys here in the room, Mr. McNamara, Ms. Garcia, and I met with one of the partners from Willkie Farr, Mary I think her name is, the attorney from Sylvia Rivera whose name alludes me, and a couple of other associates from Wilkie Farr.

Q. Approximately how long did you meet with these attorneys?

A. I met approximately for four hours last month and four or five hours last Friday.

Q. Did they give you any guidance on how to prepare for your deposition?

A. Yes.

Q. All right. Good. I'm sure they did a great job.

I will be using a few brief terms

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during the deposition. I thought we would get those out on the table before so we will have, say, shorthand between us.

The Cruz litigation, Cruz v. Zucker, is the litigation that brought us here today. If I refer at any point in time during the deposition today to the Cruz litigation, will you understand that I'm talking about the litigation that we are here for today?

A. Um-hum. I understand that.

Q. At some point I may -- we are going to be talking today probably at length about gender dysphoria. So at various points in time I may slip into using the term "GD" and when I do that, I'm referring to gender dysphoria.

Can we both agree if I start using GD, you will understand that means gender dysphoria?

A. I understand.

Q. I may at times refer to some questions that in the past before the diagnosis of gender dysphoria had be widely

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used today is my understanding, there may have been other terms that were used for a similar diagnosis to gender dysphoria. If I use the term "GD" or "gender dysphoria" and your answer would require you to refer to a prior nomenclature, a term that preceded gender dysphoria, will you let me know I need to clarify my question?

A. I didn't quite understand.

Q. You understand gender identity disorder?

A. Yes.

Q. What is that?

A. What gender dysphoria used to be called.

Q. If within my question I refer to gender dysphoria and you think the answer to would tend to refer to gender identity disorder, will you understand?

A. Yes.

Q. If I use GD, you understand?

A. Yes.

Q. At some point, I may start talking about the diagnostic mental disorders that's

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published by the American Psychiatric Association. Are you familiar with that volume, that document?

A. Yes, I participated in the latest iteration.

Q. And so can you tell me briefly, so we have that on the record, what your understanding is of the diagnostic and statistical manual of mental disorders?

A. It is a compendium of diagnoses, psychiatric diagnosis of disorders published by the American Psychiatric Association.

Q. If at some point during the course of the deposition I refer to the DSM, do you understand diagnostic and statistical value of mental disorders?

A. Yes.

Q. Is there a current version of the DSM?

A. Yes, DSM-V.

Q. Unless I tell you otherwise, if I refer to the DSM I will be referring to the DSM-V or an earlier version; can we agree on that?

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A. Yes.

MR. GASIOR: Can we mark this as Drescher A.

(Subpoena marked Drescher Exhibit A for identification, as of this date.)

Q. Dr. Drescher, the court reporter handed you a document marked Drescher Exhibit A.

Do you have that document?

A. Yes.

Q. The first page of Drescher Exhibit A says at the top issued by the United States District Court, subpoena in a civil case, Cruz, plaintiff v. Zucker, defendant, Case Number ESNY 4456. It's addressed to Jack Drescher, M.D., P.C.

Do you see that document, Dr. Drescher?

A. Yes.

Q. Have you received this subpoena prior to today?

A. Yes.

Q. And are you appearing here today pursuant to the subpoena to give testimony?

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A. Yes, I am.

MR. GASIOR: Let's mark this as Drescher Exhibit B.

(18-page report of Jack Drescher, M.D. marked Drescher Exhibit B for identification, as of this date.)

Q. Dr. Drescher, the court reporter has handed you an exhibit that has been marked Drescher Exhibit B. At the top of the page it has what appears to be a letterhead, I will characterize it as that, "Jack Drescher, M.D., P.C." and it is dated May 1, 2015 and it is comprised of 18 pages.

Do you see this document?

A. Yes.

Q. Can you tell me what this document is?

A. This is my expert witness report.

Q. And did you personally prepare the expert report?

A. Yes.

Q. Did you prepare the document that's been marked as Drescher Exhibit B?

A. Yes.

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Q. Why did you prepare this report?

A. I was contacted by Legal Aid and asked if I would prepare a report.

MR. GASIOR: It's 9:52. This might be a good time for us to stop. We will take a brief recess to have a conference call with the court and we will come back and keep things moving.

(Recess taken.)

Q. Dr. Drescher, we are back on the record. Thanks for your patience. I know we had just marked Drescher Exhibit B and I believe that we were asking about your preparation of that report or maybe --

A. You asked me who had asked me to prepare the report.

Q. I think you answered that question.

A. I did.

Q. How long did it take you to prepare the report?

A. I don't remember. I don't remember. Maybe eight hours preparation and writing the report. Together maybe about eight hours or so.

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Q. Are you being compensated by plaintiffs to give expert testimony here today?

A. Yes.

Q. Were you compensated or will you be compensated for preparing the report marked Drescher Exhibit B?

A. I was compensated.

Q. And how are you being compensated?

A. I'm compensated at a rate of $400 an hour.

Q. There is a curriculum vitae starting on -- well, it's attached as Exhibit A to your report. Do you see that?

A. Yes.

Q. Is the curriculum vitae attached to your report, the information contained there, accurate?

A. Yes.

Q. Is there anything that has been added or you would add to that curriculum that was not there at the time you prepared the report?

A. Yes, this is -- I guess this was

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October. There are probably things added to that, some papers or some lectures.

Q. Do you recall the nature of the materials that you would include on the curriculum vitae if you were to add them now?

A. Yes. I just have -- I just published an article that I got -- went published online this week on an update on the gender diagnosis on the DSM and ICD.

Q. Anything else?

A. Nothing comes to mind.

Q. If you turn to page 4 of Exhibit B under the title "Assignment," do you see that?

A. Yes.

Q. I'm going to read that, "I have been asked to assess and give an independent expert opinion on certain exclusions of coverage for gender reassignment treatments for adults with gender dysphoria in the New York State Department of Health's Medicaid regulation called Gender Dysphoria Treatment."

Does that statement accurately

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describe the topic on which plaintiffs' counsel asked you to give an opinion?

A. Yes.

Q. What specifically are you referring to in that paragraph when you refer to, "Exclusions of coverage for gender reassignment treatments for adults with gender dysphoria"?

A. I'm specifically referring to the regulation's list of excluded treatments which are deemed to be cosmetic.

MR. GASIOR: And, I'm sorry, could you read that answer back.

Q. We will get into that a little bit later on. But if you look at last part of page 3, the last part of page 3 and running over to page 4 of your report, does that paragraph accurately describe the materials that you reviewed in preparing your report?

A. Yes.

Q. So among the materials that you considered were the amended class action complaints; is that correct?

A. Yes.

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Q. And the proposed rulemaking of Regulation 18 NYCRR, Section 505.2(l) published in the New York State register of December 17, 2014; is that something you considered?

A. Yes.

Q. Is that something you considered?

A. Yes.

Q. And then the rest of the materials that are cited there, 3, 4 -- it looks like there are two number 4s. 4 is "Policy and billing guidance for regulation 18 NYCRR" and then it looks like another 4.

"The World Professional Association for Transgender Health, that should probably be a 5?

A. Yes.

Q. And so is that the universe of documents that you considered in writing the report that's been marked as Drescher Exhibit B?

A. Yes.

Q. When you were referring at -- on page 2, rather -- let me make sure I get this

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right.

On page 3 among the materials that you considered, Item Number 2 is the proposed rulemaking of regulations. Is that where you found the exclusions of coverage for gender reassignment treatments that we spoke about earlier?

A. Yes, I believe so.

Q. If you flip over to page 12 of your expert report, Drescher Exhibit B, under the heading "Conclusion," do you see that?

A. Yes.

Q. I will start reading the second sentence down, the one that begins "However while some." Do you see that?

A. Yes.

Q. Let me read that, "While some gender assignment treatments are covered, Section 5052(l) now excludes payment for some procedures that it deems cosmetic." Do you see that?

A. Yes.

Q. When you refer to 505.2(l), what do you mean?

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A. I believe I'm referring to the regulation.

Q. So if during the course of the deposition today either you or I refer to Section 505.2(l), we will be referring to the Department of Health regulation concerning coverage, Medicaid coverage, for transgender care and services?

A. Yes.

Q. Can we understand that's the shorthand we will be using?

A. Yes.

Q. It may be I will use the term "the regulation" or Department of Health's regulation or Section 505.2(l). You will understand we are talking about the regulation that is the subject of your expert report?

A. Yes.

MR. GASIOR: Can we mark this as Drescher Exhibit C, please.

(Four-page document entitled "Rulemaking Activities" marked Drescher Exhibit C for identification, as of this

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date.)

Q. Dr. Drescher, the court reporter has handed you a document that has been marked as Drescher Exhibit C.

The first page of the document is titled "Rulemaking Activities" and it is a four-page document. On page 2 at the top the header says, "Rulemaking Activities, New York NYS Register/December 17, 2014." Do you have that document?

A. Yes.

Q. Is this one of the documents that you considered in writing your expert report?

A. Yes.

Q. Can you tell me what portion of this document you considered in writing your expert report?

A. I was asked to focus on the section having to do with -- on the second page where it says "Cosmetic," Roman numeral V "Cosmetic surgery and procedures including, but not limited to" and a listing of 13 procedures.

Q. That's on page 2 of the exhibit?

A. Page 2, yes.

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Q. Do you have any understanding of what this document is?

A. I may have general sense understanding. This is a regulation issued by the New York State Department of Health saying what the -- what services the state will and will not provide for treatment of gender dysphoria.

Q. Now, this is the document refers -- on the first page says, "This is a rulemaking activity." Do you understand that the text on page 2 that relates to transgender-related care and services has become an effective regulation in New York State at this point?

A. Yes.

Q. And am I correct that this is the document that you reviewed in order to make the statement that both Section 505.2(l) now excludes payment for new procedures it deems cosmetic?

A. Yes.

Q. And if you look in the column, the bottom of column 1 on page 2 wrapping around

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to column 2 on page 2, do you see the section parenthesis number 4, "Payments will not be made for the following services and procedures"? Do you see that?

A. Yes.

Q. And then wrapping around, I think you said that it's under -- I'm not sure if you identified paragraph 4, but you did refer to Roman V which is titled "Cosmetic Surgery Services and Procedures Including, But Not Limited to." Do you see that?

A. Yes.

Q. Am I correct that paragraph 4 starts by stating, "Payment will not be made for the following services and procedures:"? Is that correct?

A. Yes.

Q. And am I correct then that paragraph 4, Roman V, is what you looked at to conclude there is an exclusion of coverage for cosmetic procedures?

A. Yes.

Q. Sometimes it takes us a long time to get to a simple point.

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So from this point forward then, if I make a reference to Section 505.2(l) and any particular subsection paragraph (4) or some other, you will understand I'm talking about the regulation that is now effective as we just looked at in Drescher Exhibit C? Can we agree on that?

A. Yes.

Q. Dr. Drescher, maybe a little bit of background now. What are your areas of professional expertise?

A. I'm a psychiatrist, a medical doctor, and psychoanalyst. And I have expertise in treating issues related to gender and sexuality.

Q. You say that you have expertise related to gender and sexuality. Can you please elaborate when you say you treat issues related to gender, what that means?

A. I have published books, chapters and articles and edited books dealing with the mental health and health of lesbian, gay, bisexual or LBG populations, publishings over 20 years.

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Q. Okay. And then you also mentioned that you have expertise related to sexuality. How does that differ then or how is it related to gender?

A. Sexuality is one area of expertise, gender is another area of expertise. Sometimes they intersected, but often they are separate categories of expertise.

Q. When you talk about an expertise related to treatment for sexuality, what does that mean?

A. That means that I write about areas of human sexuality, expressions of human sexuality, how sexuality affects people's lives, their health and mental health.

Q. Do you have a practice in treating those persons you have been speaking about writing about that? Do you also have a practice related to the treatment for issues related to gender?

A. Yes, I have a private practice in Chelsea in Manhattan and I treat patients who come in. Many of them come in with issues related to gender or their sexuality.

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Q. How long have you been treating individuals for gender or sexuality-related issues?

A. About 30 years.

Q. Do you hold any licensures in New York State?

A. I'm licensed to practice medicine in New York State.

Q. Is there a separate licensure for psychiatric services?

A. No.

Q. I'm revealing my ignorance.

A. Okay.

Q. Have you ever had any dealings with the New York State Department of Health?

A. Not that I recall.

Q. At one point you were employed I believe by SUNY Downstate; is that correct?

A. Correct.

Q. In your employment with SUNY Downstate, were you ever represented in any manner by the New York State Attorney General's Office?

A. No, I don't think so.

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Q. I asked you this, but you presently do actively practice any psychotherapy?

A. Mostly psychotherapy, yes.

Q. Any other areas of practice that you are engaged in?

A. I also treat people with medications. I see people just for psychopharmacological treatments.

Q. Do all of your clientele come to see you, who come to see you, for issues related to gender or sexuality solely?

MR. GARCIA: Objection.

A. No.

Q. Do you see individuals for other diagnoses?

A. Yes.

Q. What kind of diagnoses do you treat?

A. I treat depression, I treat bipolar disorder, I treat anxiety disorder, I treatment obsessive compulsive, assessment disorders, I treat some patients with substance abuse disorders.

Q. What percentage of your patients

would you say have issues related to gender identity?

A. Presently maybe 15 percent, 10 to 15 percent.

Q. Maybe I should back up. When I use the term "gender identity," you said you have 15 percent of your clientele have gender issues. What does it mean to you, gender identity issue?

A. These are patients that do not have conventional presentation of gender. They may be born with the body of one sex, but their subjective experience that they don't fit with the body that they were born with.

Q. Is that in any way related to gender dysphoria?

A. That is one of the criteria of making a diagnosis of gender dysphoria.

Q. Can you tell me in your expert opinion what gender dysphoria is?

A. Currently gender dysphoria is -- well, there are two meanings of gender dysphoria. It's a technical term that's been in literature for a long time basically

describing the discomfort people feel with the body to which they were born. That's the general term. The term was adopted as the name of the diagnosis in the DSM-V which used to be called gender identity disorder. The name changed to gender dysphoria. That is the name of the DSM-V diagnosis.

Q. Did you have any role in the changing of gender identity disorder to gender dysphoria?

A. Yes. I served on the DSM-V work group on gender which was tasked with the revision of the sexual revisions of the DSM-IV.

Q. Did you say you were on a committee?

A. It was a committee called the working, the work group.

Q. Do you recall who else was on the committee with you?

A. Yes.

Q. Can you please tell me who was on the committee with you?

A. The chair of the committee was

Kenneth J. Zucker, psychologist in Toronto. Peggy Cohen-Kettinis, a psychologist from Amsterdam. Freda Mongforelin, a psychiatrist ULM Germany. Hinamiya Balberg, a psychologist here in New York.

I should say there was a sub-work group on gender identity disorder and a larger committee working on other parts, working on the sexual dysfunction and the paraphilias, but working on gender identity, the sub-work group was six people. And William Wohlmark, psychiatrist from Washington State I believe. Six of us on the sub-work group working on gender identity disorder.

Q. Did you know Kenneth J. Zucker before you both served on that committee?

A. Yes, we had edited a book together.

Q. What book was that?

A. A book called Ex-Gay Research: Analyzing the Spitzer Study. It was a collection of articles that he previously published in the journal he edited and articles I published in a journal I was

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editing at the time.

Q. In what field is Dr. Zucker?

A. Yes.

Q. Do you know what field Dr. Zucker is in?

A. Child psychologist.

Q. Does he have a particular area of practice?

A. Yes. He's in charge of a clinic in Toronto where they provide services on issues related to gender and sexuality.

Q. Did I hear you correctly that Dr. Zucker was the chair of the committee that --

A. He was the chair of the larger -- the entire work group of sexual and gender disorder with Cohen-Kettinis.

Q. Do you know how Dr. Zucker came to be named as chair of that committee?

A. I believe he was the second choice of the APA or committee. As part of the larger DSM process, anyone who earned more than $10,000 a year from a pharmaceutical company was excluded from being able to serve

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on the DSM-V committee.

And I believe the first choice was -- who was a psychiatrist, they wanted a psychiatrist first, apparently did have some funding from pharmaceutical companies so he was not allowed to do that. So he chose Dr. Zucker who served on the committee for DSM-IV, a member of that committee.

Q. So do you have any knowledge about Dr. Zucker's reputation within the community of people who treat gender dysphoria issues?

A. Yes.

Q. Can you tell me what your opinion is?

A. Of his reputation?

Q. Well, I actually think I misstated that.

I think you understood what his reputation was in the community. Can you tell me what his reputation is in the medical community?

A. I think he is a respected researcher in the trans-community. People don't like some of his purpose treating

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children, prepubescent children.

Q. Why is that?

A. His clinic -- the approach of his clinic is to try and prevent adult transsexualism. And transsexualism is another term for gender dysphoria, a term used as a synonym for gender dysphoria. His approach is to try to prevent adult transsexualism in children that appear with gender dysphoria.

Q. Do you have an expert opinion yourself about the methods employed by Dr. Zucker?

A. Yes, I do. I don't believe Dr. Zucker has proven that his method does prevent gender transsexualism. And I have published those opinions.

Q. Okay. Let me just see if I -- Dr. Zucker has not proven --

A. -- that he can prevent transsexualism in gender dysphoria of children.

Q. We will come back to that later. For right now, I would like to finish with

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your expertise.

I think we mentioned where you had described what gender dysphoria is. Have you treated adults with gender dysphoria?

A. Yes.

Q. Approximately how many?

A. Somewhere between 60 and 70.

Q. Did any of the adults with gender dysphoria you treated have gender dysphoria as a child or as an adolescent?

A. Yes.

Q. Do you know approximately how many of those?

A. I don't know.

Q. Was the type of treatment -- let me back up and say: Did you prescribe treatment for any of those individuals, the adults who had been, had gender dysphoria as a child?

MR. GARCIA: Objection.

Q. Do you understand my question?

A. No.

Q. Of those individuals who are adults with gender dysphoria who you treated who had had gender dysphoria as a child, talking

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about that group of people, was the type of treatment that you provided to that adult informed by the treatment that they received as a child?

A. No.

MR. GARCIA: Object to form.

Q. So that had no impact how you would treat them, the kinds of treatments they received as a child had no impact how you treated them as an adult?

A. No.

Q. Why not?

A. Because the child, the childhood presentation, is not necessarily relevant how you would treat an adolescent or adult patient.

Q. Why not?

A. Because it's not.

Q. Is it relevant at all to know what kinds of treatments a child received for gender dysphoria than to know how an adult is presenting with gender dysphoria?

MR. GARCIA: Object to form.

A. I don't understand the question.

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Q. That's probably a very bad question. Maybe this is asking the same question again then.

So is your opinions about the treatments of adults with gender dysphoria shaped by the kinds of treatments that are available to adolescents with gender dysphoria?

A. I don't understand the question.

(Record read.)

MR. GARCIA: Same objection.

A. It doesn't make sense, the question doesn't make sense to me.

Q. Probably doesn't make sense then. Let me see if I can think of a way that asks it in a way that makes sense.

Are the kinds of treatments -- strike that, let me start again.

Are treatments that a child with gender dysphoria receives likely to have an impact on the kinds of treatments they will need as an adult if they have gender dysphoria?

MR. GARCIA: Object to form.

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A. Could you say the question again.

(Record read.)

A. Yes, that's possible.

Q. And under what circumstance would that be possible?

A. So if a child receives, for example, puberty suppression, that child may have a very different clinical presentation as an adolescent or adult of gender dysphoria as a child who did not receive puberty suppression.

It's likely the child that did not receive puberty suppression will have more gender dysphoria because their body would have gone through pubertal changes that will make them more dysphoric. Someone born a boy will develop an Adam's apple, a beard and growth of their penis and their dysphoria would be greater than a child whose puberty was suppressed and be more comfortable with their body. And of course that would have implications of treating them if you met them as an adolescent or adult.

Q. I believe I asked you if you've

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treated adults with gender dysphoria in your -- is it a private practice?

A. Yes, private practice.

Q. In your private practice, have you treated adolescents with gender dysphoria?

A. I treated adolescents as young as 19 years old who are still considered adolescents, but 19 is probably the youngest I've treated.

Q. I was going to make a distinction between treating children. So I do understand the youngest patient you have had where you treated them for gender dysphoria is 19 years old?

A. Correct, and I'm not a child psychiatrist.

Q. What types of treatments did you provide to people of the age of 19?

A. Treatment has included medication. Treatment for depression and anxiety, treatment has included psychotherapeutic support for patients who might, who have been suicidal. Treatment has been exploration of the gender dysphoria, treatment has included

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exploration of feelings about transsexual. Generally I think that covers it.

Q. While you have not treated in your private practice individuals under the age of 19 with gender dysphoria, have you engaged in any research of gender dysphoria persons who are either adolescent or children?

A. I have studied the issue of treatment of gender dysphoric children in younger adolescents.

Q. And by "study," what do you mean?

A. I have edited a book on treating transgender children in adolescence in which people who actually treat the children were invited to present what they do and explain it to, you know, a general professional audience. And invited experts in the area of gender sexuality, but not in this area to participate in this book to offer comments about their thoughts about the various treatment approaches to children's adolescence. I've written articles about the controversies surrounding the treatment of prepubescent children and I have written

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articles about ethical issues that the treatment approaches may raise.

Q. I may have asked you this, but when did you begin treating patients with issues related to gender identity?

A. In the 1990s.

Q. And what was the nature of the treatment that you provided in the 1990s? And let me maybe give that some context. Is it any different than the kind of treatments you are offering today?

A. Well, I'm better at it now.

Q. One would hope.

A. No, I mean, patients -- patients who come in with, have always come in with treatments not only related to gender dysphoria, but also related to depression, anxiety and other issues they are dealing with. And I think that's still the case. It's never about gender dysphoria. There are often other things going on.

Q. Is there a term you use "co-occurring conditions," would that be the term you would use for someone who has gender

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dysphoria, but then there are --

A. Comorbidity.

Q. I will try to use that term later on.

In your practice for the treatment of gender dysphoria, do you make a recommendation or does part of your prescription for the treatment of gender dysphoria ever include a recommendation for surgical procedures?

A. I have not written a letter to do surgery.

Q. By "written a letter," I think you said for surgery?

A. For surgery.

Q. What do you mean?

A. In order for people who wish to transition surgically, to have the procedure you usually need at least one letter from a mental health professional recommending it. That has not come up in my practice.

Q. So you have never been asked by anybody nor have you ever written such a letter that would say, I believe this person

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is --

A. Candidate.

Q. -- a candidate for surgical procedure to treat gender dysphoria?

A. I have not written such a letter.

Q. How about any kind of recommendation for treatment involving hormones; have you done that?

A. No, I have not had to write a letter for that either. Mostly because the people that I have referred, the doctors haven't asked for letters for hormone treatment.

Q. Any of the individuals that you have treated for gender dysphoria at the time you were treating, were they presently taking hormones to treat gender dysphoria?

A. Yes.

MR. GARCIA: I would like remind you to allow Mr. Gasior to finish the question.

Q. It will make your attorney happy if you allow me to finish the question.

If I understand your testimony, you

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were not the doctor who prescribed hormones for them?

A. I don't prescribe hormones. That's usually an endocrinologist or internist that does that.

Q. Let me ask you some general questions at this point. What is gender identity?

A. Gender identity is a term formed in the 1960s by a psychiatrist Stoller, S-T-O-L-L-E-R, Robert Stoller, which is an individual's inner sense of being male, female or some other gender.

Q. Is gender identity a term that's currently used today?

A. Yes.

Q. Is there any medical consensus about what factors may contribute to form gender identity?

A. Nobody knows what causes a transgender identity or SIS, S-I-S, gender identity refers to -- it's a term from the transgender community that refers to people who are not transgender.

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Q. So does the term "SIS gender" cover everybody that is not transgender?

A. In the terms of the transgender community, yes.

Q. Is that how you use the term?

A. Yes.

Q. Is an individual's gender identity permanent or can it change over time?

A. That may vary. For most people gender identity is fixed, for some people it is not.

Q. Is there a consensus in the field of psychiatry as to the cause of gender dysphoria?

A. The cause of gender dysphoria is not known.

Q. Do you have a professional opinion about the cause of gender dysphoria?

A. No.

Q. Is it part of your practice to make a diagnosis that someone has gender dysphoria?

A. I make a diagnosis of gender dysphoria if the person meets the diagnostic

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criteria.

Q. Are there any psychiatric conditions that should be ruled out before a psychiatrist can make a confident diagnosis of gender dysphoria?

A. Yes, there are several exclusionary diagnoses listed in the DSM you want. Sometimes psychosis can be confused with gender dysphoria. Sometimes just having gender atypical feelings or behavior can be confused with gender dysphoria. Sometimes people have body dysmorphic disorder discomfort with their body that may be confused with gender dysphoria. Those are some of the things you may want to rule out.

Q. The things you just spoke about, are those what we earlier called or what you earlier described as comorbidity?

A. No, those are exclusionary diagnoses. Meaning when you make a diagnosis, you want to separate the diagnosis you are making from other possibilities. By example, if you go to see your doctor for a cough, he might want to rule out a viral

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infection versus bacteria versus pneumonia as cause. So you are looking at more than one diagnoses, you want to be more precise in making the diagnosis.

Q. So when we are talking about comorbidities with a diagnosis of gender dysphoria, what are we talking about?

A. Comorbidity refers to in addition to gender dysphoria, they have other diagnoses. So one is a list of things you don't have and one is a list of things you might have in addition to gender dysphoria.

Q. With respect to the list of things you don't have, what kind of -- if you are making a diagnosis where you are thinking maybe this is gender dysphoria, what kinds of things are we talking about that it's not?

MR. GARCIA: Object to form.

You may answer.

A. Well, a person for example who has a psychotic delusion about their body, that could be interpreted as gender dysphoria. But then you look for other signs of psychosis. And if you were to treat the

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psychosis, usually the delusional material would go away. So that person doesn't have gender dysphoria, they have a psychotic condition. That's how you make a distinction from one diagnosis to the other.

Q. Anything other than psychosis that might fit that category also?

A. Well there are gender atypical presentations, that some people are not conventional in the way they think their gender is and that doesn't necessarily mean they have gender dysphoria. A person might, for example, might like to cross-dress, but they don't feel uncomfortable in their bodies. They just like to cross-dress, that would not be a diagnosis of gender dysphoria.

Q. In terms of gender dysphoria, you spoke about comorbidities. Are there any particular comorbidities that occur that present along with gender dysphoria?

A. Well, there is research showing that there are some correlations between gender dysphoria and autism spectrum disorders. Why there's a correlation is

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unknown. There just seem to be higher percentage of people with gender dysphoria that may have some type of autistic disorder.

Q. What is an autism spectrum disorder?

A. Now we are out of my area of expertise, but autism is a psychiatric condition in which the capacity for interpersonal relativeness is effected and people are somewhat detached from other people in severe cases. Some cases they may have some social skills, but not have, you know, average social skills perhaps less than average social skills.

Q. Did I understand your testimony there are recent studies which seem to find that --

A. Correlation.

Q. -- a correlation between gender dysphoria and autism spectrum disorders?

A. Yes.

Q. Do you know when those studies -- when did those studies start to come out?

A. I'm not certain. Perhaps in the

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'90s. Definitely in the '90s.

Q. Do I understand your testimony correctly to say the studies don't show why there's a correlation, just there is a correlation?

A. Yes, that is correct.

Q. We spoke earlier about the DSM-V, do you remember that?

A. Yes.

Q. Am I correct there are criteria for making a diagnosis of gender dysphoria in the DSM-V?

A. Yes.

Q. Are the criteria for diagnosing gender dysphoria in the DSM-V now generally accepted within the field of psychiatry?

A. Yes.

Q. If you would, take a look at your expert report which has been marked as Drescher Exhibit B. And on page 6, do you see that?

A. Yes.

Q. On page 6 --

A. Yes.

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Q. -- is what is listed in the first paragraph, and there's text below that, criteria A, criteria B. Is that the -- what is that, what is listed there?

A. Those are the criteria from the DSM-V directly copied from the DSM-V.

Q. And there is a criterion A and criterion B. What is criterion A, generally speaking?

A. Criterion A is -- basically describes the form that the dysphoria takes subjectively within the individual. What are the -- I guess one would say the symptoms, you know, of gender dysphoria.

Q. And then below that is criterion B. What is generally meant by criterion B?

A. Criterion B, in all of, in every DSM diagnosis has a distress and dysfunction criteria. Which means in order to meet the standard of being a psychiatric disorder, the condition must cause some distress or impairment and function. So it's a standard criterion for all DSM-V disorders.

Q. In criterion A it says, "A marked

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congruence runs between one's experience expressed gender and assigned gender of at least six months duration as manifested by at least two or more of the following:"

Is there -- strike that. Let me start again.

Why does criteria A require duration of at least six months of gender incongruence?

A. The idea for duration of time is that it shouldn't be a transient phenomenon. It's around for a while. So the idea is that somebody shows up, you know, in one week they are feeling some incongruence but it goes away, it probably wouldn't meet criteria.

Q. There is a temporal element that you need to see in order to make a diagnosis of gender dysphoria?

MR. GARCIA: Object to form.

A. Yes. The idea is that you don't want to treat transient phenomenon as if they were a diagnosis as if they met the diagnostic criteria.

Q. Is that temporal criterion

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something used with respect to other diagnosis besides gender dysphoria?

A. Yes. It's common, for example, if you are making a diagnosis of depression, there's like nine symptoms to make a diagnosis of major depression. And it must be present for at least a week or two.

Q. Is there ever a reason why a psychiatrist might want to take longer than six months to make a diagnosis of gender dysphoria?

MR. GARCIA: Object to form.

You may answer.

A. Yes. It's possible, for example, that the patient might not be two of the six criteria, but might meet one very intensely. So you might want to wait to see if another symptom emerges more powerfully and more intensely before you make a diagnosis.

Q. Criterion A I believe you said are -- you would describe as symptoms; is that correct?

A. Yes.

Q. Does the assessment of the symptoms

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that are listed in criterion A depend entirely on self-reporting by the patient, by the individual.

A. In adults and adolescents, yes.

Q. Is there some other group on which that would not be the case?

A. In children they may not portal. Some of the symptom reports come from family or schools.

Q. And looking at criterion B -- criteria A you called or generalized as symptoms.

Criteria B, is there a -- how would you characterize that? You called them distress or impairment. Is there somehow you would categorized what is described here?

MR. GARCIA: Object to form.

A. Criteria, yes, because you would say of that -- any DSM diagnosis you would say do the patients symptoms also meet the distress criteria.

Q. If we call these distress criterion, you understand what I was talking about?

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A. Um-hum.

Q. The distress criteria listed in criterion B for gender dysphoria, are these unique to gender dysphoria?

A. I don't quite understand the question.

Q. Well, it talks about the condition which I assume means gender dysphoria, correct?

A. Yes.

Q. So the condition of gender dysphoria and I quote from B "is associated with clinically significantly distress or impairment in social, occupational or other important areas of functioning."

You saw that text? Is that unique to gender dysphoria or do other diagnoses share those criteria?

A. The language of criterion B is boilerplate and used in all DSM diagnosis. The form of distress and impairment varies from diagnosis to diagnosis. So the distress and impairment that one finds in diagnosis of gender dysphoria takes a form unique to that

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diagnosis, which might be different than the distress and impairment say from a diagnosis of depression or psychosis.

Q. When you saw the form of distress, are we talking about the symptoms?

A. It could include the symptoms listed in the A criteria, but it could also lead to other kinds of symptoms which might involve anxiety, depression, inability to get to school, inability to get to work which are not specifically the A criteria.

Q. Those things you just described, are those comorbidities?

A. If the depression -- you can be depressed, but then not might meet depressive criteria then you have comorbidity. You can be depressed, but not depressed enough to meet criteria, then would not be exactly a comorbidity.

Q. I think I got you.

Is a gender dysphoria a permanent condition?

A. Gender dysphoria, which appears first in adolescents or adulthood, is usually

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a permanent condition except when it's treated and then the gender dysphoria diminishes.

Q. Is that true in all circumstances?

A. I don't -- nothing is 100 percent, but many people do benefit from treatment and their gender dysphoria gets better.

For example we have in the DSM-V, we have added something called a post-transition specifier which means that a person had all of the symptoms and met diagnostic criteria for gender dysphoria. But they received treatment, medication, surgery, it may depend on the individual what treatment they received and they are no longer experiencing the dysphoria because they are now in the gender role. They feel themself comfortable in being, but they still have a diagnosis with a specifier called post-transition specifier because their ongoing healthcare requires some type of diagnosis. DSM-V for the first time has, as I said, a post-transition specifier.

Q. Now, in your answer to the question

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that is gender dysphoria a permanent condition, I believe you started off by saying in adults and adolescents. Is there something different about children?

A. Yes.

Q. What is that difference?

A. Prepubescent children who present with gender dysphoria may not be gender dysphoric later on. Sometimes it resolves before puberty, sometimes resolves at puberty, sometimes it resolves a little after puberty.

Q. In the context of children who are being evaluated for gender dysphoria, have you heard of the term "persister and desister"?

A. Yes.

Q. What do those terms mean to you?

A. A desister is a child, prepubescent child, whose gender dysphoria stops at some point for reasons unknown. And persister is a child whose gender dysphoria continues into adolescence, again, for reasons unknown.

Q. When you say that there are some

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children who desist for reasons unknown, what percentage of children desist?

A. In the current research it may vary anywhere from 10 to 50 percent, depending on the study. I think that's the range.

Q. In your experience, is there any particular time in a person's life when criteria B to the DSM-V gender dysphoria criteria -- is there any particular point in a person's life when criteria B tends to be more prevalent?

MR. GARCIA: Object to form.

A. Yes, I don't -- I don't quite understand the question.

Q. In that person's lifespan if they have experienced gender dysphoria, is there a particular age range when gender dysphoria tends to be more prevalent?

A. I don't think it's related to age. I think what you see, people at different times in their life if they have not received treatment for the gender dysphoria, it may wax and wane. It may be more severe distress then at one point in their life than it would

be at another time in their life. Again, that may be related to various circumstances.

A person who is gender dysphoric, did not get treatment for that decides to stay in the -- you know, in the gender to which they have been assigned at birth. Some family tragedy occurs and their gender dysphoria may get worse. It may be provoked by external circumstances.

Q. So when you said that the gender dysphoric can wax and wane --

A. In some individuals, yes.

Q. And do I understand your testimony that it can be a variety of circumstances that cause that to happen?

A. Correct. And directly to your question, I don't think it's necessarily related to a certain age or a particular age. I think it's more varied in terms of how that might happen.

Q. Does the intensity of gender dysphoria -- is it correct to talk about intensity of gender dysphoria, could it be greater and lesser?

A. Yes.

Q. Does the intensity waxing and waning have any relationship to the kind of treatment that's being provided?

A. It could.

Q. Under what circumstance?

A. Well, if someone is receiving inadequate treatment, for example, then it would be you would get exacerbation of gender dysphoria. There are -- this is not from my practice. This is from things I read in the paper of transgender people who are incarcerated. And depending on the prison which they find themselves, they may or may not have access to the hormones they were taking before they were incarcerated. So the stopping of their treatment while they are in prison has certainly worsened the condition. They may become suicidal, for example.

Q. On page 6 of your report, Drescher Exhibit B, at the bottom of the page the paragraph that begins "The changes to the diagnostic criteria."

A. Yes.

Q. "The changes to the diagnostic criteria are significant for a number of reasons. In the DSM-IV the GID criteria for adolescents and adults were somewhat vague and for some even lack a reference to intensity or frequency of the diagnostic criteria."

What do you mean by the "intensity or frequency of the diagnostic criteria"?

A. The -- well, by frequency we talk about duration, for example. And intensity refers to how strong the feelings are.

Q. Has the DSM-V included those types of criteria for considerations?

A. Right. For example, if you look at 6-A all refer to a -- criteria 2 through 5 refer to a strong desire. The idea is to sort of provide clinicians with a sense this is not a casual feeling, but a very strong feeling.

Q. Am I correct that the intensity -- when you talk about intensity, are we talking about criterion B or criterion A?

A. Criterion A.

Q. The intensity which those criteria are felt is part of criterion A?

A. Right. And DSM-IV, the criteria were not teased out in this way. They are all sort of lumped together in a paragraph. So the idea was to sort of -- what are the most likely, you know, predicators for making a diagnosis, could you elaborate them more specifically. That was how the six criteria were laid out to provide guidance with the numbers in the manual.

Q. Is it part of what a clinician treating dysphoria does to evaluate the intensity?

A. Yes, it should be. Yes.

Q. How does the clinician do that?

A. Through experience, you meet people who have a wide range of expression of any range of symptoms. You know, if you are working with an anxious patient, some are mildly anxious and some people are very, very anxious and certain kind of experience that comes, a certain kind of knowledge that comes with clinical experience.

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Q. To what extent does the clinician's evaluation of the intensity depend on what they are told by the person they are treating?

A. Well, much of it is guided by what people say. I mean, psychiatric diagnosis have a strong degree of patient self-report in making the diagnosis. Some of the symptoms are reported from the outside. Some diagnosis with many symptoms are basically based on patient report, self-report.

Q. You used the term "outside"?

A. Right. You make a diagnosis of depression, for example, just as an analogy, most of the symptoms include things like I'm not sleeping at night, I feel hopeless and helpless, I feel tired during the day. Majority of patients have subjective symptoms. But one symptom dies, does the patient then restrict psychomotor retardation or psychomotor activation. Are they all speeded up is visible, that is something you would see the patient do. But majority of symptoms are patient's self-report.

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MR. GASIOR: Would it be okay if we took a bathroom break.

(Recess taken.)

Q. Dr. Drescher, in your practice, how do you express marked incongruence in a person who you are assessing for gender dysphoria?

A. Again, it's taking a history how long the person had the feelings, you know, how have the feelings changed over time, what is the nature of the incongruence, what exactly do they -- is the person experiencing that's different. That's what is the person experiencing in terms of is it about their body, is it about the presentation, is it about their wish to be rid of parts of their body, is it about the wish to have a different kind of body. Because it's not -- as you see from the 6-A criteria, you know, there are different presentations. Some people want to be rid of body parts, some don't. So it's a way you have to like look at the different possibilities.

Q. This might be related to a question

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I asked earlier: In assessing a person for a gender dysphoria, how do you assess clinically significant distress or impairment?

A. Well, the way to do that, talk about what is going on in their life; are they working, are they in school, how is the school function, how is the work function, are they married, are they in relationships. You get a sense whether the person's life is going well or not, that would be the impairment functioning in terms of distress. They present with depression or anxiety or suicidal feelings, those are three most common presentations of distress.

Q. When you say three most common --

A. -- clinical presentations --

Q. -- of distress, that is with respect to gender dysphoria?

A. Yes. Yes, in the sense that's correct. You know, if I -- you know, if I have to -- if I can't live like a woman, I'm going to kill myself, for example, would be

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an example of the distress and gender dysphoria.

Q. If you would, turn to page 9 of your expert report marked as Drescher Exhibit B. At the bottom of the page under the heading "Gender Dysphoria Treatment," do you see that?

A. Yes.

Q. You make the statement, "It should be noted that GD is a unique psychiatric diagnosis." Do you see that?

A. Yes.

Q. What does that mean, what do you mean by that?

A. What I mean is what follows in the sentences after that.

Q. Why don't I read that then. Following what I just read, "Most psychiatric diagnoses are aimed at reducing psychological symptoms by either psychotherapy or behavioral or medication interventions until those symptoms are gone. For example, a patient with symptoms of depression DSM-V or depressive disorder is given medication that

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make the symptom exacerbate.

For more than half a century the medical and psychiatric consensus regarding treatment of GD, physically changes the bodies with this condition rather than changing their minds. Due to the uniqueness of this diagnosis and the accepted treatment guidelines of transforming the affected individual's body who tends to move ICD equivalent diagnosis of transsexualism out of the mental disorder section and into a new chapter, conditions related to sexual health."

With respect to the saying that most diagnoses are aimed at reducing psychological symptoms in contrast to medical psychiatric treatment of GD by physically changing the bodies rather than changing their minds, can you tell me why gender dysphoria is different in this way?

MR. GARCIA: Object to form.

A. My understanding is that in the early/middle of the 20th Century when treatment of gender dysphoria became more

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common, that consensus of the experts was that they could not change the minds of people who had this condition and that it was futile to try. And the only thing they could do was to accommodate the ways to change the body. And since the techniques for those changes were available as in hormones and surgical procedures, that's how the treatment I think began at that time.

Q. So when you make the statement beginning of that paragraph starting on page 9 at the bottom that gender dysphoria's unique psychiatric diagnosis, is there, to your knowledge, any other psychiatric diagnosis where the treatment involves surgical procedures?

A. Yes, there is one other. I forget the name of it, but it is a diagnosis in which people wish to have body part amputated. It's not in the DSM. It did not make it into DSM-V. I think it's in the appendix of future diagnoses. There is condition of people who seek out amputation, either an arm or a leg, and they have found

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surgeons who sometimes will do that for them.

Q. Is that bodily integrity identity disorder?

A. I believe so, yes.

Q. And is it your testimony now that you believe that I will call it BIID is listed in the DSM-V in an appendix, is that what you said?

A. I'm not 100 percent certain it's listed as an actual diagnosis.

Q. I was trying to think of other examples where somebody experienced the kinds of distress or impairment listed in criteria B of gender dysphoria. Other symptoms -- strike that. Let me start again.

I was trying to think of where there might be distress or impairment experienced by somebody because of some psychological condition. It might be equivalent to gender dysphoria if somebody were to be demonstrating clinically significant distress or impairment in social, occupational or other important areas of functioning because of a desire to be, for

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example, of a different race.

Are you aware of any support in the psychiatric community that would be appropriate to provide such a person with treatment that would physically change their skin color?

MR. GARCIA: Object to form.

A. I'm unaware of anybody who would provide such treatment.

Q. So am I correct then that in terms of psychiatric diagnosis treated by a surgical or hormonal treatments that are intended to change the body, that gender dysphoria is unique except for bodily identity integrity disorder, to your knowledge?

A. To my knowledge, yes.

Q. Are you familiar with the term "primary sex characteristics and secondary sex characteristics"?

A. Yes.

Q. Can you tell me what your understanding of primary sex characteristics is?

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A. Primary sex characteristics refers to genitals. Secondary sex characteristics refer to the body features, body parts associated with adult sexual development. Facial hair is secondary characteristic, pubic hair is secondary, breast development is a secondary sex characteristic. Adam's apple is a secondary sex characteristic.

Q. When we were looking at the Regulation 505.2(l) and you were looking at the exclusions of certain procedures, is it your understanding that those procedures were intended or are intended to treat secondary sex characteristics?

A. Yes.

Q. In your practice in treating gender dysphoric people with gender dysphoria are you, the treating clinician, who would decide whether one of your patients with gender dysphoria requires a particular surgical procedure to address secondary sex characteristics?

A. I am not the person who would decide that. I might be asked to weigh in

with an opinion, but I'm not the person who decides that.

Q. When you say you are asked to weigh in with an opinion, what do you mean?

A. Well, if the person -- if a person wants treatment, you know, the treating physician might want to say what do I think, but I'm not the person who decides.

Q. You mentioned treating physician?

A. Right. These treatments are all medical treatments that are provided either by endocrinologist, primary care internists or surgeons.

Q. Am I correct if somebody with gender dysphoria wanted to have a tracheal shave, that it would be the primary physician who would decide whether that was appropriate but not you?

A. Correct.

Q. So among the universe of treatments that could be provided to somebody who has gender dysphoria and that might help them to -- let me back up and start again.

In terms of treatments for gender

dysphoria, what is the goal of those treatments?

MR. GARCIA: Object to form.

A. By treatment you mean --

Q. The overall of the treatments that might be provided, what is the overall goal of those treatments?

A. By treatment, do you mean medical or surgical interventions?

Q. Okay, let's start there.

A. The goal of medical and surgical interventions in the treatment of gender dysphoria is to reduce the dysphoria, to reduce the feeling of incongruence between the person's body and the sense of the gender, who they are.

Q. Is it necessary in trying to determine what is going to help reduce incongruence that you just described, to determine whether those procedures that might help do that are medically necessary?

MR. GARCIA: Object to form.

A. I don't understand the question.

Q. Well, with respect to the types of

treatments that could be offered to somebody with gender dysphoria, in order for those treatments to take place is it necessary for the clinician or primary caregiver, the primary treater, to make a determination that those treatments are medically necessary?

A. What do you mean by "medically necessary"?

Q. Do you have any understanding what the term "medical necessity" means in the context of treating somebody with gender dysphoria?

A. My understanding of medical necessity is a term made by insurance companies to decide what they will and will not pay for. Physicians rarely prescribe treatment that they don't think is medically necessary. Of course there might be exceptions, but ethically we don't. We do what we think is medically necessary.

Q. And how does a person treating somebody with gender dysphoria, a caregiver, care provider, make that determination what is medically necessary to treat the gender

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dysphoria?

A. There are established protocols of treatment and established protocols of treatment are part of the -- depending on the patient's subjectivity, not all patients require all treatments. So it's a collaborative effort between the patient and treater to sort out what symptoms the patient has and what interventions would be helpful in reducing the patient's symptoms.

Q. When you use the term "protocols," what do you mean?

A. The WPATH, all capital P-A-T-H, WPATH standards of care.

Q. And so do I understand you to say that the WPATH standards of care contain protocols for making determinations of what is medically necessary?

A. They have listings of all the kinds of procedures that are involved in the treatment of gender dysphoria to reduce dysphoria.

Q. Do you rely upon the WPATH standards of care in your practice?

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A. The WPATH standards of care don't really outline what psychological treatments might be necessary. They allude to them and talk about that sometimes they are necessary and helpful, but they don't really have psychological guidelines for treatment.

Q. So in terms of your practice and what you do for persons with gender dysphoria, is it correct to say that the WPATH standard of care really doesn't address your area of treatment?

MR. GARCIA: Object to form.

A. Well, the WPATH standards of care suggests that clinicians be familiar with gender dysphoria, they have some expertise in the area, that they be sensitive to some of the issues, sensitivities of people, you know, who have gender dysphoria. But in terms of what medications you use for the depression or anxiety or how, you know, how to discuss one's life and treatment, that's not really in the WPATH standards of care.

Q. And just so I'm correct, in your earlier testimony you are not the individual

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with respect to somebody -- you are treating for gender dysphoria that makes the determination there should be a surgical procedure to treat gender dysphoria?

A. Correct. That is referred to as the gatekeeper function of mental health function, which is a traditional function of mental health, but not used as much as it used to be.

Q. The term "gatekeeper" --

A. The gatekeeping function is not what it used to be. In the middle of the 20th Century, the role of the mental health professional was to seek out what was then referred to as the true transsexual. So if you were born in a man's body and you wanted to be a woman, you felt you were a woman and wished to transition, but you were attracted to women, for example, the mental health professional would make the assessment you could not make the transition because the gatekeeping function was to treat heterosexual people at the end of transition. So that was one of the examples of the

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gatekeeping function.

So it was -- so what often used to happen is that people in the trans-community who got to know each other before, you know, they would prep each other, you know, on the right thing you had to say to the doctor in order to get through the gatekeeping function of doctors. They had to adhere to a certain narrative in order for you to get treatment. So that's not really going on because nobody cares anymore about your sexual orientation as part of your transition. It's not a clinical issue anymore.

Q. Do I understand your testimony this gatekeeping function is not as prevalent anymore as it used to be?

A. Yes.

Q. And so were you testifying that in some sense you serve as a gatekeeper?

A. I don't serve as a gatekeeper.

Q. I have to come back to that later.

MR. GASIOR: If we could, I would like to mark this as Drescher Exhibit D.

(Booklet entitled "Standards of

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Care for the Health of Transsexual Transgender and Gender Nonconforming People" marked Drescher Exhibit D for identification, as of this date.)

Q. Dr. Drescher, the court reporter has handed you a document which has been marked as Drescher Exhibit D. On the front page it says in the upper left-hand corner, "WPATH," W-P-A-T-H all caps, "World Professional Association for Transgender Health" and has the title "Standards of Care for the Health of Transsexual Transgender and Gender Nonconforming People."

Do you see that?

A. Yes.

Q. And I will refer to this as the standards of care, is that okay?

A. Yes.

Q. Are you familiar with the standards of care?

A. Yes.

Q. What is the standard of care?

A. The standards of care is a consensus document produced by a

professional, international professional organization called the World Professional Association for Transgender Health or WPATH.

Q. Is there a document which you utilize in your practice?

A. It's a document I occasionally refer to in my practice.

Q. Is there a document you utilized in preparing your expert report that's marked Drescher Exhibit B?

A. Yes.

Q. Would you turn with me to page 27 of Drescher Exhibit D. Do you have that?

A. Yes.

Q. Do you see the first full paragraph there, the one that begins "The SOC"?

A. Yes.

Q. Let me read that quote, "The SOC do not state criteria for other surgical procedures, such as feminizing or masculinizing a facial surgery; however mental health professionals can play an important role in helping their clients to make fully-informed decisions about the

timing and implications of such procedures in the context of the overall coming out or transition process."

Do you see that?

A. Yes.

Q. Do you have an understanding when it says that the SOC do not state criteria for other surgical procedures, feminizing or masculinizing facial surgery?

MR. GARCIA: Object to form.

Can you read that back.

Q. Let me say it again. That statement the standard, the SOC standards, that SOC refers to standard of care, is that what you understand?

A. Yes.

Q. The SOC do not state criteria for other surgical procedure such as feminizing or masculinizing facial surgery, what is your understanding the SOC do not state criteria for those procedures?

A. In my understanding, in contrast to what follows in terms of the surgery where they list specific criteria, you know, their

criteria are not as specific for surgery basically for sensory assigning surgery.

Q. When you say not as specific, are there any criteria for -- strike that.

When it's talking about other surgical procedure, feminizing or masculinizing facial surgery, are those surgeries which could be called cosmetic?

MR. GARCIA: Object to form.

A. Well, they don't use the term "cosmetic." They use it feminizing or masculinizing facial surgery, so it's since part of gender dysphoria is one feels feminize or masculine after transition.

Q. When you talk about feminizing or masculinizing, what kind of procedure is being referenced there?

A. I'm not sure of specific procedures to -- sort of feminizing surgery to, for example, shave the Adam's apple down. Some people they have -- born a man they have prominent chins, they may need chin reduction. For example, perhaps their nose is more masculine looking than a typical

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female. So those kind of procedures.

Q. If you were to look at what has been marked as Drescher Exhibit C on page 2 and that was the list of procedures under paragraph 4, Roman V that we looked at earlier, do you see that?

A. Yes.

Q. We are talking about breast, brow or face or forehead lifts. Are those the types of procedures you were just describing on page 27 of the standards of care?

A. Yes.

Q. And so the procedures that were just described in the standards of care on page 27 would correspond to the types of procedures that are listed in paragraph 4, Roman V of the regulation; is that correct?

A. Yes.

Q. And they may have been calling them cosmetic procedures in the regulations, but what we are talking about are the same procedures just being described on page 27 of the standards of care; is that correct?

A. I believe so.

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Q. We were sort of talking over each other, okay.

Do you have any understanding of why the standards of care published by WPATH don't state criteria for the surgical procedures that we just looked at on page 27?

A. Although I'm not part of the WPATH standards of care development process, I'm not privy to how they -- how they came to this decision. I have no idea.

Q. Are you aware of any situation or circumstance as part of your experience as a treating clinician for people with gender dysphoria with Adam's apple, aware of any circumstance where you would ever conclude that treatment like those that are described in paragraph 27 -- let me stop.

If we can use for shorthand purposes, whether you agree with -- just for shorthand purposes that when we are talking about the treatments that are described on page 27 of the standards of care which we said corresponded to those listed at paragraph 4, Roman V of the new regulation,

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if I say "cosmetic procedures" will you understand I'm talking about those procedures limited in paragraph 4-V of the regulation? I'm trying to get some shorthand.

A. I would understand. But I would prefer to talk as standard of care does, feminizing or masculinizing facial surgery.

Q. Let me maybe back up. In that paragraph where it talks about feminizing or masculinizing facial surgery, is it your understanding that that's the universe of procedures that the standards of care does not describe or are those examples of other procedures?

A. I don't know the answer to that question.

Q. Do you know of any other place in the standards of care where it talks about surgical procedures that are -- strike that.

I believe your testimony was the standards of care describe procedures that are recommended for basically genital reassignment surgeries; is that correct?

A. Correct.

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Q. And that procedures such as feminizing or masculinizing facial surgeries are in distinction to that; is that correct?

A. I'm looking at my copy of the standards of care remembering somewhere a list of procedures. I may be remembering something else.

MR. GARCIA: I think he pointed out something on page 57. I will ask if that's what he was referring to.

THE WITNESS: Yes, page 57. This lists all of the surgical procedures. Thank you.

Q. So we are looking at page 57, an overview of surgical procedures for patients with gender dysphoria. What particular portion of this page are you looking at?

A. I'm looking at -- they list all of the possible surgical procedures first for male-to-female patients and then female-to-male patients. And so they divided up into breast, genital and nongenital, non-breast surgical interventions. Those are the three categories used in the standards of

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care.

Q. With respect to those in item 3?

A. Yes.

Q. Are those surgical procedures related to secondary sex characteristics or primary?

A. Secondary sex characteristics.

Q. I will come back to this topic in a little bit. Let's just move on to something else.

In your report on page 9 where we had discussion on there, you said gender dysphoria is a unique psychiatric diagnosis. Can you please list for me in the ways that it is unique?

MR. GARCIA: Object to form.

A. I believe I answered that question.

Q. If you could, give me a general --

A. It's unique in that the treatment of the subjective symptoms is not to change the person's mind, but to change the person's body.

Q. And I believe that your testimony was that except perhaps for bodily identity

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integrity disorder, you are not aware of any other psychiatric diagnosis where the treatment regimen that's employed by the medical community is to perform surgery or to use hormones to change the body; is that correct?

A. That is my understanding.

Q. On page 9 of your report you make note that adults with gender dysphoria have significant patterns of comorbidity, including --

MR. GARCIA: Can you point me to where you are talking about?

MR. GASIOR: In the fourth line from the top.

A. I see that.

MR. GASIOR: Where it says, "Studies have shown significant comorbidity for adults with GD."

Q. Do you see that?

A. Yes.

Q. What kind of comorbidities are we talking about?

A. Depression, depressive disorders,

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or mood disorders, anxiety disorders, substance abuse disorders.

Q. Now, to your knowledge, those comorbidities conditions, are those with respect to gender dysphoria, are they causative or are they co-relative?

A. I don't think the answer to that question is no. I mean, there are people that believe minority stress is the cause of depressive anxiety and substance abuse disorders, but the research there is sketchy in the sense almost all studies have been done with convenient samples in studies of small number of patients.

Q. How do persons with gender dysphoria tend to fair with respect to their comorbid conditions after they have gone gender transition?

MR. GARCIA: Object to form.

A. Well, the data that does exist suggests that transition which has been common in a way, that's consistent with standards of care tends to reduce psychological and psychiatric symptoms and

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leads to both increased patient satisfaction and better psychological adjustment.

Q. Are there any long-term studies that demonstrate that?

A. Well, the Dutch have published a study last year in pediatrics in which they have been following young people who were prepubescent with their gender dysphoria into their twenties. So they have been following the kids 15 or 20 years and their study shows the kids are good outcome treatment.

Q. How would you rate the quality of those studies?

A. I'm not sure what you mean by rate the quality of the study.

Q. Well, in terms of their reliability, how would you rate them?

A. Well, this is a small study. I think it was about 55 patients. It's a perspective study, which is a good study. It was a study that measured the kid's function at various ages around puberty, a few years later when they started hormone treatment, and after surgery. So I think it's a good

study.
Q. You said it was a relatively small study?
A. 55 patients.
Q. Is that relatively small in your estimation?
A. For this patient, this is a rare condition. So for this patient population, this is actually a large study.
Q. On page 12 of your report at the top paragraph there, you reference a 2001 study from Sweden --
A. Yes.
Q. -- concerning rates of regret following gender transition which rates applying for a reversal of legal gender status following reassignment. Do you see that?
A. Yes.
Q. Now, was this study based on a valuation of Swedish citizens, people in Sweden?
A. Yes.
Q. Are you familiar with any studies

that define regret differently?
A. No.
Q. Is it your understanding this was a study testing for regret rates?
A. Yes.
Q. And do you know of any studies on this issue after 2001?
A. This is -- this study is 2014.
Q. Sorry. How did I get 2001 out of that. Right. Forget that question.
Are you aware of any other studies that measure regret rates?
A. None that immediately come to mind, no.
Q. Are you aware of any studies' regret rates that were based on an evaluation of persons in the United States as opposed to Swedish people?
A. Not that I'm aware of.
Q. Are findings by a Swedish study of Swedish people distinguishable from the experience of persons with gender dysphoria in the United States?
MR. GARCIA: Object to form.

A. Can you read the question back.
MR. GARCIA: Same objection.
(Record read.)
A. I think they could be seen as helpful in understanding patients of the United States.
Q. What do you mean by "helpful"?
A. I mean gender dysphoria, the diagnostic that -- the Swedes question the same diagnostic criteria used in the United States for gender identity disorder. I think they are studying the same kind of patient population, so I think it would be an applicable piece of information.
Q. Does gender dysphoria have social context?
MR. GARCIA: Object to form. I don't understand that question.
Q. Can the experience of gender dysphoria by a person be influenced by the social context in which they live?
A. Again, I'm not sure I understand what you mean by the "social context."
Q. Well, the culture in which a person

lives, can that be an influence on gender dysphoria if a person does have gender dysphoria?
A. Can that be an influence you mean by the distress or dysfunction of the person for social context?
Q. Okay, let's start with that.
A. I don't know.
Q. So can the social context or the cultural context by which a person lives influence the severity of gender dysphoria?
A. I don't know the answer to that question. My response is more like, you know, when we try and create a psychiatric diagnosis, we try and talk about what goes on within the person. And while it's true that it's possible that the people around that person might have different responses to a person, most of the symptoms for gender dysphoria are based on the subjective experience of the person whether they are comfortable with their body. So I'm not sure what -- how the social context would make a difference in that regard in terms of making

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a diagnosis.

Q. Are you familiar with the term "minority stress"?

A. Yes.

Q. What does that mean?

A. Minority stress, there's a literature that talks about the kinds of experiences that people were members of ethic or sexual or racial minorities or religious minorities experience day-to-day life.

Q. Do people with gender dysphoria experience minority stress?

A. Some do, yes.

Q. And in the context of gender dysphoria, how does minorities distress, what is the relationship between those two?

A. Again, this is -- there are people who suggest that minority stress is one of the causes of increased depression and anxiety and substance abuse in sexual and gender minorities. But, again, that literature is not robust.

Q. Do you know if there are any differences in the incidence of minority

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stress in persons with gender dysphoria in the United States as opposed to people in Sweden?

A. I don't know that.

Q. Dr. Drescher, would you agree or disagree with the statement "All psychiatric diagnoses occur within a cultural context"?

A. Yes, I agree with that statement.

Q. Why do you agree with that statement?

A. Well, a lot of my work has been not so much in the gender diagnosis, but homosexuality diagnosis area as resolved around, you know, trying -- how we make the psychiatric diagnosis we have are always made -- always have some cultural aspect to them because a psychiatrist is involved in determining what constitute acceptable social behavior versus unacceptable social behavior.

So the classic example of that would be the diagnosis of Drapetomania, D-R-A-P-E-T-O-M-A-N-I-A, which is a diagnosis from the 19th Century given to slaves who had a wanderlust and would repeatedly run away

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from the plantation. Some of the southern doctors could give a diagnosis to slaves trying to escape. That's a perfect example.

So the introduction of homosexuality into the diagnostic manual was always in a cultural context. The introduction of sexual diagnosis paraphilias have a cultural context expressing the societies' disapproval of certain sexual practices. So in many cases there is a cultural context.

On the other hand, there are diagnoses like schizophrenia whose prevalence seems to cut across cultures. The prevalence of schizophrenia, that seems to be the same no matter what culture you look for it. Sometimes we think of schizophrenia as a diagnosis, is more of a brain disease than some of the other psychiatric diagnoses.

Q. Does the diagnosis of gender dysphoria occur in any general context?

A. Like I said, every diagnosis occurs with the context. So, for example, the inclusion in the DSM was because

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psychiatrists were very interested and that's how it found its way in the DSM-III in 1980. And there's no reason to think that it's a mental disorder any more than some other disorder because we don't know what causes it. And so the World Health Organization is planning to take it out of the mental disorder section and forthcoming revision of an international classification of diseases or ICD-11, capital I-C-D.

Q. Would there be any implications if gender dysphoria was removed as a disorder?

A. Yes.

Q. What would that mean?

A. Well, there were calls during the DSM-V recision process to remove the gender diagnosis from the DSM the way homosexuality was taken out in 1973 and the working group did consider that question. It was the consensus of the group and of the APA, the removal of the diagnosis would deprive people of a medical rationale for receiving treatment.

In order to get any kind of medical

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treatment, you need a code and the diagnosis code to get the treatment. The APA had a binary choice in or out. The ICD includes all diagnoses, every diagnosis that your doctors use when you go for a physical, whatever, will include an ICD code. And so the ICD has the option of moving it around within its manual so you can retain the diagnosis. So people can obtain access to care, but it doesn't have to be a mental disorder diagnosis.

Q. So do I understand your testimony to be that the diagnosis of gender dysphoria was retained in the DSM-V in order to allow persons with GD to access medical care?

A. That was one of the rationales, yes.

Q. Were there other rationales?

A. Well, there's an entity called Gender Dysphoria that does exist, so it is a condition.

Q. Dr. Drescher, do I understand that you are now serving on the World Health Organization's working group on sexual

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disorders and in sexual health?

A. Yes.

Q. What role are you playing?

A. I'm a member of the group.

Q. Are you engaged in any current activities with respect to the World Health Organization's work group?

A. Presently I am working with two other members of the group on submitting a paper for publication related to the work of the work group.

Q. And the work with the work group is what?

A. The work group is charged with assessing the diagnoses that were in the ICD-10 to decide which ones should stay and which ones should leave and which ones should be modified in making recommendations to the World Health Organization about what should appear in the ICD-11.

Q. When there is a new, you would call it a version of the ICD set to be published?

A. There's a beta version online.

Q. Does the beta version online in any

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way differ from the DSM-V in its diagnostic approach to gender dysphoria?

MR. GARCIA: Object to form.

A. The recommendations which are on the beta version is for diagnosis of gender incongruence in childhood and gender incongruence in adults similar to gender dysphoria, but it would have a different name.

Q. Is the difference in name only?

A. The ICD does not produce the same kind of diagnostic criteria format that the DSM uses, so it is a little bit different. But essentially it would be parallel to the DSM criteria, the DSM diagnosis.

Q. Am I correct that the DSM-V does not make any recommendations in terms of treatment for the diagnosis of gender dysphoria?

A. That is correct.

Q. Is that true also for the ICD-11 --

A. ICD-11, I'm not sure.

Q. Let me finish the question.

Is that true also for the ICD-11,

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that it doesn't have any treatment recommendations for gender dysphoria?

A. I am not entirely sure what the final format of ICD-11 would be. I know that we -- one of the inhouse documents that we prepared in terms of laying out what we thought the criteria were for the diagnosis is that -- in children is that it's a specialized form of treatment and should only be done by people who have knowledge of how to do the treatment. Whether that will actually appear in the ICD-11, I'm not sure.

Q. Am I correct there is an ICD-10?

A. Yes.

Q. Has the ICD-10 had any recommendations for the treatment of gender dysphoria?

A. No.

Q. This will be repetitive, but in preparing your report for this case the document that's been marked as Drescher Exhibit B, am I correct that you reviewed the WPATH standards of care?

A. I do.

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Q. You are familiar with the WPATH standards of care?

A. I am.

Q. Are you familiar with any other standards of care other than the WPATH standards of care for the treatment of gender dysphoria?

A. I don't believe there are any other standards of care.

Q. Are you familiar with an organization called Hayes, H-A-Y-E-S, Inc.?

A. Only from having read the Hayes report as part of my preparation for this deposition.

Q. Other than reviewing the Hayes report as part of your preparation for this deposition, as part of your preparation for this deposition other than that have you any experience at all with the Hayes reports?

A. No.

Q. Have you used the Hayes reports in your professional practice at all?

A. No.

Q. If you turn to page 13 of your

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report, on page 13 about the third line down there is a sentence that begins "In some ways." Do you see that?

A. Yes, in some ways.

Q. I will read that, "In some ways Section 505.2(l) appears consistent with the treatment aims of the WPATH SOC."

Do you see that?

A. Yes.

Q. What did you mean by that?

A. Well, Section 505.2(l) which I have here in front of me. So if you look, original page 2 of Exhibit C, it allows for hormone treatment, allows for surgical treatment. It asks in 3-I that the individual has a persistent and well-documented case of gender dysphoria, has received hormone therapy appropriate to the person's gender goals. In the case of gender therapy, unless if the individual is otherwise unable to take hormones has lived for 12 months in a gender role congruent with the gender identity and received mental health counseling deemed mentally necessary

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during that time, has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery and so has the capacity to make a full informed decision and consent to treatment.

Those are all consistent with the WPATH standards of care. I don't think these were manufactured out of thin air. They seem to become -- these seem to be conditions within the WPATH standards of care for surgical treatment.

Q. Okay. At the bottom of page 13 of your report where we were just reading, you state that -- it's the final paragraph, "The current DOH Medicaid policy."

By that, are you referring to the Regulation 505.2(l)?

A. Yes.

Q. I will continue, "The current DOH Medicaid policy in its exclusion for procedures deemed cosmetic appears to connotate a transgender individual's medical need for procedure to successfully complete a

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gender transition with a non-transgender individual's vanity-based non-medically necessary desire to improve appearance. In so doing, Section 504.2(l) prohibits medically necessary care."

Do you see that?

A. Yes.

Q. What do you mean when you use the term "vanity-based non-medically necessary desire to improve appearance"?

A. Well, I think in reading the regulation which calls these procedures cosmetic which I put in quotation marks in my statement, they are treating these activities as simply a wish for persons not wishing to improve their appearance for variety of reasons such as 19-year-old SIS gender girl who wants a nose job as opposed to procedures which are part of reducing gender dysphoria which is a medical condition requiring medical treatment. You know, I think my nose is too big is not currently considered a medical condition by most of the people. Although, there's a medical treatment

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rhinoplasty someone deemed cosmetic and not paid for by insurance because it's not deemed medically necessary, but for a person's choice.

Q. With respect to vanity-based desires --

A. That because there is a social prejudice, again to the wish to have cosmetic surgery because one wishes to improve one's appearance presumably for purposes of looking better, which is what I mean by vanity-based.

Q. Is there a cultural component to a vanity-based desire to improve one's appearance?

A. There could be, but there could be a personal desire. Some people seek out cosmetic surgery beyond what they actually need.

Q. What do you mean seek beyond what they need?

A. Well, I guess although I never personally examined him before he died, Michael Jackson comes to mind. He had small cosmetic surgeries in the late '80s and '90s

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to change his appearance and then he continued to have plastic surgeries. So to outside observers it was -- looked like he has relatively bizarre facial skin.

Q. So do I understand your testimony to say that with respect you use the example of a SIS gender girl wanting a nose job, would you consider that a vanity-based desire?

A. Often it may be.

Q. Can that have a cultural component, to want that type of vanity-based procedure?

A. It could.

MR. GARCIA: Object to form.

Q. Is that true in the United States, that people get vanity-based surgeries based on cultural?

A. I am not an expert on why people get cosmetic surgeries.

Q. You use the example of a SIS gender girl who wanted a nose job. Are transgender individuals immune to vanity-based desires to improve their appearance?

A. No.

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Q. To the extent that a transgender individual were to seek out a procedure that was solely to improve their appearance, would you consider such a procedure medically necessary?

MR. GARCIA: Object to form.

A. I would say that that would be -- you would have to look at that on an individual basis. You know, it would -- I have not personally had such a case, so I don't know what I would do in such a situation. But I would imagine it would require the individuals' input from the treating physicians because they will have opinions on that.

Q. But if the conclusion was that the transgender person was seeking a cosmetic procedure simply because they wanted to improve their appearance, would you consider that treatment then to be medically necessary?

MR. GARCIA: Object to form.

A. I'm not sure I understand the question.

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Q. Let's assume that you have a transgender person who has come in and after an assessment by various treating professionals, the determination was made that the reason they wanted a rhinoplasty to use your example of SIS gender girl who wanted it for vanity-based reasons, if the determination was made that the transgender person wanted the rhinoplastic only to improve their appearance, but not to treat gender dysphoria per se.

A. If a treatment -- if a treatment would reduce gender dysphoria, then I would consider it medically necessary. If the treatment seemed unrelated to gender dysphoria, then probably wouldn't be by insurance terms medically necessary.

Q. So would a transgender person who came in and had gender dysphoria but the determination was made that the procedure they were looking for, rhinoplasty or some of the other procedures listed in the regulation at 505.2(l), if they were purely to enhance their appearance, to improve their

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appearance, would you consider that medically necessary?

MR. GARCIA: Object to form.

A. Well, again, we are talking hypotheticals and I think it's more complicated than that. I think you really have to be able to, you know, sort out whether or how much it related to gender dysphoria or not. And since I have never seen such a case like that before, I'm reluctant to say what I would do in that situation.

Q. Is it fair to say that it is possible as with a SIS gender person, a transgender person could be motivated to get a quote/unquote cosmetic procedure for vanity-based reasons?

A. I would say it is possible, but I think that is not a reason, significant justification to have to have a blanket for the procedures without input from treating practitioners.

Q. So your answer to my question is yes?

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A. It is theoretically possible.

Q. For a transgender person to want a quote/unquote cosmetic procedure? And when I am talking about cosmetic procedures, the procedures listed in the regulation at paragraph 4, Roman V, just using cosmetic procedure as shorthand.

A. We are talking about a rhinoplasty. I don't think, for example, a male-to-female transsexual person who wants electrolysis is simply looking for a vanity-based procedure.

Q. But is it beyond possibility that a transgender person would seek that type of procedure solely for a vanity-based reason?

A. Anything is possible.

Q. But is that possible?

A. Anything is possible.

Q. How does a medical practitioner who is treating a person with gender dysphoria differentiate between a patient's vanity-based desire to improve their appearance and a procedure that is medically necessary to alleviate the suffering caused by gender dysphoria?

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A. I don't know that there's a specific procedure for doing that. I would assume that if a person came up with such a situation -- I have never come up against such a situation -- it would be a question of knowing the patient, you know, knowing something about their gender dysphoria over the course of treatment, having some grasp of whether they are subjectively able to -- you know, how they think about themselves as a person, whether they like themself as a person. It's complicated. I don't think there's a particular one-answer-fits-all way to do that.

Q. So if I understand your testimony, to be to make that determination as to whether it's medically necessary or a vanity-based desire on the part of the person is a complicated issue?

A. I would says it's a complicated issue, yes.

Q. It's not easily resolved?

A. As I said, I have never come across it so I've never had to sort that out. What

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I'm referring to in my expert report is a decision of people who are going to pay for the services, trying to sort out what they want to pay for and what they don't want to pay for. And sometimes the way these decisions get made are not as black and white as the regulation that says absolutely no.

Q. If you look at Drescher Exhibit C and we are looking at the Regulation 505.2(l) and you were looking at paragraph 4, Roman V, correct?

A. Yes.

Q. And paragraph 4-V, I will read it without looking at Roman I-2, 3 and 4, okay, because we are focusing on Roman V. If I read that and follow along with me at paragraph 4, "Payment will not be made for the following services and procedures:"

Jump to Roman V, "Cosmetic surgery services and procedures including, but not limited to" and then there's a list, correct, of procedures? So am I reading that correctly?

A. Yes.

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Q. And then if you move down below that there is a paragraph V, is there not?

A. Yes.

Q. Do you see that?

A. Yes.

Q. I'm going to read that. Paragraph V reads, "For purposes of this subdivision, cosmetic surgery services and procedure refers to anything at solely improving that individual's appearance."

Do you see that?

A. Yes.

Q. In preparing your expert report, did you review paragraph V that I just read?

A. Yes.

Q. And did you reach any conclusion what that text means?

A. Yes, that's the regulation. I think my last paragraph in my direct report directly address this is interpretation of the surgical procedures for transgender patients as being cosmetic, meaning simply to improve appearance unrelated to the issue how these procedures actually are about reducing

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gender dysphoria.

In reality, improving appearance and reducing gender dysphoria are often quite linked to each other through these kind of interventions. This report tries to say this is simply about improving the appearance without a context of gender dysphoria.

Q. Looking at paragraph V of the regulation when it says that for purposes of this subdivision, cosmetic surgery and procedures refers to anything solely directed as improving an individual's appearance --

A. Right, this is an opinion of the regulation.

Q. Well, is it saying that if one of those procedures that's listed there in Roman V and it's A through M, if one of those procedures is for something other than solely directed as improving the person's appearance that there might be coverage for those procedures?

MR. GARCIA: Object to form. Calls for a legal conclusion.

MR. GASIOR: He referred to this in

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forming his opinion for this, for his expert report. He did make some conclusions about paragraph 4-V and I want to know what his opinion is with respect to paragraph V.

MR. GARCIA: Same objection.

Q. Would you like the question read back, Dr. Drescher?

A. Yes.

(Record read.)

A. So my reading of the regulation was that the listing of the role of the procedures in paragraph Roman numeral V was that they were defining all of those procedures as solely directed as improving the individual's appearance, that that was the definition. First they called them cosmetic. They call them cosmetic and they say we are not doing anything cosmetic. That's how I read the regulation.

Q. What does paragraph V mean when those procedures are solely directed at improving individual's appearance?

MR. GARCIA: Object to form.

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A. As I said, I read it that they are referring to these procedures as cosmetic and they are not going to provide for those services.

Q. We may come back to that. Let me mark it.

MR. GASIOR: We will mark this Drescher Exhibit E.

(Document entitled "Medicaid Update" marked Drescher Exhibit E for identification, as of this date.)

Q. Dr. Drescher, the court reporter has handed you what is marked Drescher Exhibit E, the first page of which is entitled "Medicaid Update." It has the New York State Department of Health I will call it letterhead at the top of the page dated March 2015.

Dr. Drescher, is this one of the documents that you reviewed as part of your preparation of your expert report, Drescher Exhibit B?

A. Yes.

Q. Is there a particular part of the

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document that you referred to in preparing your report?
A. Yes. On page 15, "Medicaid Updates Regulation."
Q. So page --
A. -- 15.
Q. Am I correct that the portion you are referring to on page 15 says "New York State Medicaid Updates Regulations"?
A. Yes.
Q. And then the paragraph begins, "In response to litigation filed in federal court by several organizations, the Department of Health revised its regulations to repeal the existing prohibition on Medicaid coverage for transition-related transgender-related care and services."
Is that correct?
A. Yes.
Q. Was there some other particular part of this update that you looked at?
A. Yes. Original page 16 of the update says in the middle of the page that, "Payment will not be made for the following

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services." And then under that paragraph it lists what it calls cosmetic surgery in the same procedures that are listed in the regulation.
MR. GARCIA: I would like to remind Dr. Drescher to allow Mr. Gasior to finish his questions.
MR. GASIOR: Can we mark this as --
THE WITNESS: After this we need to break.
MR. GARCIA: This would be a good time to take a break so we can make copies.
(Recess taken.)
MR. LANDSMAN: Let's take lunch.
(Luncheon recess: 12:52 p.m.)

J. Drescher, M.D.
A F T E R N O O N S E S S I O N
August 11, 2015
1:44 p.m.
(Document entitled "Medicaid Update" dated June, 2015 marked Drescher Exhibit F for identification, as of this date.)
Q. Dr. Drescher, back on the record. The court reporter has handed you what has been marked as Drescher Exhibit F. It is a New York State Department of Health document titled on the first page "Medicaid Update," the date June, 2015.
Do you see that document?
A. Yes.
Q. Have you seen this document before, to your recollection?
A. Yes.
Q. When was the first time you saw this?
A. I saw this on Friday.
Q. Turn with me to page 7 of Drescher Exhibit F. And I don't know if you still have Drescher Exhibit E with you.

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A. Yes.
Q. If you could, pull page 7 of Drescher Exhibit F next to page 16 of Drescher Exhibit E. That might help with the questions I'm about to ask.
Looking at Drescher Exhibit F on page 7 do you see, "Payment will not be made for the following services"?
A. Um-hum. Yes.
Q. And would you agree with me that there is a difference between the text that is in Drescher Exhibit F and Drescher Exhibit E?
A. Yes, there is a difference.
Q. In Drescher Exhibit F there is a sentence that begins, "Payment will not be made for." Do you see that?
A. Yes.
Q. I will read from that, "Payment will not be made for any procedures that are performed solely for the purpose of improving individual's appearance. The following procedures will also be presumed to be performed solely for the purposes of

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improving appearance and not be covered unless justification of medical necessity is provided and prior consent is obtained."

What do you understand Defendants' Exhibit F June, 2015 to be?

MR. GARCIA: Objection.

A. It appears as if they have the June guidance which made -- which said they would not pay for services, said there might be an exception for payment.

MR. GASIOR: Can you read the answer back.

(Record read.)

Q. What did you mean "there might be an exception"?

A. It reads that -- it says, "The following procedures will be presumed to be performed solely for the purpose of improving appearance and will not be covered unless justification of medical necessity is provided and prior authorization is received."

Q. Having now seen the June Medicaid guidance, do you still conclude as you do at

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the bottom of your report on page 13 that the new regulation excludes cosmetic procedures?

MR. GARCIA: Objection.

A. Well, this is not a change in the regulation. This is just a change in the guidance regulation. Still say they will not pay for it.

Q. Would the June guidance suggest to you that they will provide coverage for these procedures?

MR. GARCIA: Objection.

A. It's suggestive of the possibility. But since it says -- it's almost like you are saying you are guilty until proven otherwise, because it will not be paid for unless you jump through a few hoops to do that.

Q. Is it necessary in some circumstances for individuals who are receiving Medicaid to jump through some hoops, to use your terminology?

MR. GARCIA: Objection.

A. I don't know that much about the Medicaid system.

Q. Do any of your patients receive

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coverage through Medicaid?

A. No.

Q. So let me explore that then. What familiarity do you have with the Medicaid program as it's administered in New York State?

A. I work in SUNY Downstate, there as a resident for three years and as an attending psychiatrist for nine years. And many of the patients were Medicaid patients, but I -- but the clinical faculty is completely detached from the Medicaid billing and activities of that sort.

Q. So do you have any familiarity with whether procedures performed on behalf of persons who are receiving Medicaid in New York State must be approved for medical necessity?

MR. GARCIA: Object to form.

A. My practice in that area was just before managed care of medical practice began in the '90s. I left the hospital system in '93, so there was not a lot of that. But I recall, for example, I used to perform

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electroconvulsive therapy on hospitalized patients who had Medicaid and we did not require prior approval to get that treatment. Which is very expensive, by the way.

Q. Are you familiar with any procedures that are afforded by Medicaid in New York State which require prior approval, prior authorization?

A. I think I know that some medications can now be prescribed without prior authorization. That's about all I know.

Q. Are you familiar with any procedures or services whereas a precondition to receiving treatment under Medicaid in New York State, that the person seeking the treatment or their provider must show there is a medical necessity for that treatment?

A. No.

Q. If you will please turn to page 11 of your report, Dr. Drescher, Exhibit B. And in the first full paragraph, the one starting "The diagnosis of GD," do you see that?

A. Yes.

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Q. Let me read that, "The diagnosis of GD involves how an individual feeling about her own gender and how others perceive her gender."

Do you see that?

A. Yes.

Q. What do you mean by that statement?

A. Well, the symptom, the criterion A if you look at on page 9, I think we have the DSM criteria.

MR. GARCIA: May I direct him.

Page 6.

A. Page 6 of Drescher Exhibit B, my report.

Q. Got it.

So if you look on page 6, criterion A, there are six DSM criteria. And if you look at criteria 1, 2, 3, 4 and 6, five of the six criteria all are about the patient's subjective experience of their gender in various relationship to their body.

A. Criteria 5 is a little bit different because it's about the person's relationship to others and it's a strong

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desire to be treated as the other gender. And that particular symptom, for example, is highly dependent on appearance for the most part.

So the individual's ability -- as I said, how others perceive her gender, you know, can she go into the appropriate restroom, gender restroom without any incident or any kind of problem having to do with appearance. Because that can be a problem for many transgender people whether they are using public restrooms, whether somebody will object. People often object if you are walking in the restroom in the airport. People might say you are going into the wrong room or if you are in the room people might say something more strongly. That's what I mean.

Q. In that sentence, do you mean that the diagnosis of gender dysphoria depends in part how other individuals perceive the patient or does it depend how the patient feels about how other persons perceive them?

MR. GARCIA: Object. May I have

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that read back.

MR. GASIOR: Let me break it up into two parts. That might make it a less opaque.

Q. By that statement that we just read on page 11, do you mean that the diagnosis of gender dysphoria in part depends on how other individuals perceive the person with gender dysphoria?

A. Yes, how other people perceive the individual has a strong impact if the person have symptom number 5.

Q. Does it also involve or is it the same thing -- maybe I'm inflating the two, but does that diagnosis also depend how a patient feels about how other people perceive them?

A. It's very complicated. I'm not sure you can tease it out so easily. To be treated as the other gender is an interactive process with others. And there are many subtleties to the process how one is treated as a gender person.

You walk -- you know, you walk into

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a department store to buy some clothing, you know, and, you know, you see a clerk and you say I want -- I'm looking to buy some shoes. That clerk will automatically direct you to the men's department without thinking about it. But if you were more gender ambiguous, that person might not know what department to direct you to because there's women's department and men's department.

These kind of subtle activities go on all the time and this is the kind of subtly that people with gender dysphoria people trying to pass to the other gender are always aware of, you know. It's complicated because if you are SIS gender, you don't think about these things at all because you take your gender performance for granted, which these patients do not.

Q. Is there any other psychiatric diagnosis where the diagnosis depends how people perceive that person?

MR. GARCIA: Objection.

A. Well, there are some diagnoses in which, for example, the diagnosis of

attention deficit hyperactivity in children is based on information provided by the teachers in the child's school.

Q. Maybe I didn't ask the question right. I'm not talking so much about information that's conveyed to help assessing whether the diagnosis has been made.

As I understood your answer, with respect to gender identity involves how others perceive their gender. So that's part of the diagnosis of gender dysphoria, how other people are perceiving that.

Is there another diagnosis that also has that component of those diagnoses being based on how that person is perceived by other people?

A. I do believe the criteria for the children's dysphoria are, in fact, based upon adult perceptions of the child which go into the school reports of difficulty the child doesn't report. I'm having trouble concentrating, the teacher reports the child can't keep still and do their homework. And that is treated as a diagnostic criteria.

Q. Is that part of the diagnosis based on the child knowing that they are being evaluated?

A. I don't understand the question.

Q. It seems to me like in your last answer you said that part of the diagnosis for one of those childhood diagnoses, you were saying it's based on the teacher making a report --

A. Clinician.

Q. -- to the clinician saying, this is what I'm observing?

A. The clinician will have access to some information that comes from a teacher, which would fit -- which would meet the diagnostic criteria of can't keep still in school or doesn't pay attention in school or behavioral problems in school.

Q. As I understood your testimony about gender dysphoria, part of the dysphoria is caused by the person's perception how they are being viewed by other people; is that correct?

A. Yes.

Q. So my question then is: Are there other diagnoses where the diagnosis is based on that person's perception of how they are being viewed by other people?

A. Not exactly in the same way, no.

Q. In some other?

A. The closest I can come to where another person's perception is part of making the diagnosis is the example I gave you. This is a very unique diagnosis, gender dysphoria.

Q. If I refer to and if I speak about a gender-confirming procedure part of the therapeutic program, what does that mean to you?

A. Gender conforming is a term that comes out of the trans-community itself. The notion of transgenderism as written about by SIS gender people who are mostly the people who began early writing and research on treating transgender people is that the normal state of affairs is that one's body and one's gender should align automatically. And if they didn't, what you were doing was

changing sexes for example.

So gender reassignment surgery used to be called sex reassignment surgery. The sex you were born into was referred to as the biological sex, meaning it was thought to be the natural sex. With a growing transgender community for whom their final gender after transition feels to them as the correct gender, gender reassignment surgery is sometimes called gender confirmation surgery for example. At the end, they are who they actually feel themselves to be. So that kind of language is all about from a transgender subjectivity a normalization of their experience. At the end it was not that I was ever a boy and now I'm a girl or man and I'm a woman. What they are saying, I have always been a woman and now I have confirmation thanks to treatment of who I really am.

Q. So then to use that term "gender-confirming procedure" in your opinion, is the necessity of a gender-confirming procedure whether the person objectively is able to pass or whether

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they subjectively believe they are able to pass as the desired gender?

MR. GARCIA: Object to form.

A. I didn't fully understand.

Q. That's a rough one, I know. I have been working on it a while.

A. Welcome to my world.

Q. Let me see if I can take a stab at that again. In talking about the necessity of a gender-confirming procedure, is the necessity for that -- strike that. I will start again.

Maybe the better way to put this: Should the goal of a gender-conforming procedure be to allow the person to objectively pass as the desired gender or is it whether the person should subjectively believe they are passing?

A. The answer to that is that the -- whatever the procedure is, ideally it should reduce the person's gender dysphoria. Since it's possible for some of that to be subjective and some of that to be objective, again, it would have to be individualized for

the patient.

Q. How does one assess the objective success of a gender-confirming procedure from an individual?

A. That's a very difficult question to answer. I'm not sure I know the answer objectively.

Q. Is it part of what a clinician does who is treating gender dysphoric people to try and assess whether the person is passing objectively?

A. In general when you are treating a patient who has gender dysphoria and they are undergoing procedures or undergoing procedures to affirm the gender they feel themselves to be, you can see whether -- what usually happens is that their levels of distress of anxiety, of depression and their level will diminish and their levels of function may normalize or improve. Those are some of the objective criteria you might use, because basically one is always assessing in some clinical way, you know, the mood of the patient and as well as the function of the

patient.

Q. In considering the types of procedures that are listed in the regulation at Paragraph 4-V, I hesitate to use cosmetic procedure, in considering those procedures --

A. They are non-approved procedures.

Q. No, let's call them potentially approved.

If a person is a person who is transgender receiving some of these procedures, is there a point at which the procedures might become more about idealization of the body rather than insuring that that person has been able to no longer have a dysphoria with respect to their body?

MR. GARCIA: Objection.

A. Hypothetically anything is possible. I have never seen such a patient, but hypothetically anything is possible.

Q. How many patients you treated have received some of the procedures listed in the Regulation 4-V?

A. That's a good question. Maybe about 40 to 50 percent, but I would add that

my practice skews toward a number of patients who do not seek medical transition.

Q. What do you mean "medical transition"?

A. Meaning they are people that have not sought hormones or any kind of medical treatment for their gender dysphoria.

Q. So when they are seeing you, what type of treatment are they seeking?

A. Just psychological treatments.

Q. So run that percentage past me again. What percentage of the people you are seeing don't seek either a surgical --

A. 50 to 60 percent.

Q. Let me finish the question so we can get it down.

What percentage of the people you see do not seek either a surgical or drug-related therapy?

A. 50 to 60 percent.

Q. Do you know whether the percentages that you are seeing are reflective of other practitioners treating people with gender dysphoria?

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MR. GARCIA: Objection.
A. I don't know.
Q. Do you know of any studies or literature that addressed that issue?
A. No.
Q. If you look at your report, Drescher Exhibit B, on page 11 at the bottom of the page there is a large block quote -- am I correct that is a quote from the WPATH? Bottom of the page, your report at page 11 the last full paragraph it says, "In light of such clinical situations, the WPATH SOC devotes a section of the question of what constitutes 'reconstructive versus aesthetic surgery' and reads as follows:"
Do you see that?
A. Yes.
Q. If you look at the quote that follows, am I correct this is a quote from the standard of care?
A. Yes.
Q. The second full paragraph there it says, "Unfortunately, in the field of plastic and reconstructive surgery (both in general

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and specifically for gender-related surgeries) there is no clear distinction between what is clearly reconstructive and purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components."
Do you agree with that statement?
A. I am not sure. I included the quote from WPATH because I think it makes a case for the muddiness of terms when it comes to what is cosmetic versus reconstructive. I'm not sure that I -- most surgeries are cosmetic. Certainly there is a muddiness that has to be teased out on a one-by-one basis.
Q. The WPATH uses the term "reconstructive" and a contrast with what is purely cosmetic. Do you see that --
A. Yes.
Q. -- in that quote I just read?
A. Um-hum.
Q. When the standards of care uses that term "reconstructive," what is your understanding of that term in the context of

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treatment of gender dysphoria?
A. I'm not sure they are talking about gender dysphoria in terms of reconstruction. They are talking about things like surgery for mastectomies where they reconstruct the breasts after double mastectomy or perhaps the kind of surgery, plastic surgery done for people who are burn victims who have to have a lot of plastic surgery after they are medically stable after they have been burned, but they continue to have plastic/reconstructive treatments to try and recreate something similar to what they used to look like before their burns. I think that's how they mean reconstructive here.
Q. Does that term "reconstructive" have application to the procedures performed for transgender people as part of the care?
A. I think from a transgender perspective, yes, just in the sense we talk about the term "gender confirmation surgery" for the transgender. The end gender is the reconstruction of who they really are.
Q. The quote I read from the standard

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of care used the term "plastic surgery." Would you apply that term "plastic surgery" to those procedures listed in the regulation under paragraph 4, Roman V?
A. Well, some of the procedures listed in 4, Roman numeral V are plastic surgery procedures. Prior drugs for hair growth is not a plastic surgery procedure. Voice therapy is not a plastic surgery procedure.
Q. Some of them listed in 4, Roman V, 5 plastic --
A. Yes.
Q. Let me jump down to the next paragraph in the quote from the standards of care, the one that begins "While most professionals." Do you see that?
A. Yes.
Q. Third paragraph of the quote from the standards of care --
A. Yes.
Q. -- let me read that. "While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree

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other surgical procedures (breast augmentation, facial feminization surgery) can be considered purely reconstructive."

Do you see that?

A. Yes.

Q. Do you agree with that statement?

A. I don't know the answer. I don't know whether opinions diverge or not. That might mean opinions diverge in WPATH, but I don't know what it means.

Q. Do you understand that section that I just read to be referring to the procedures referred to there as being performed in conjunction with treatment of gender dysphoria?

A. I didn't understand the question.

Q. Is what they are talking about there when they are saying --

A. "There" being where?

Q. The sentence I just read, that what they are talking about there is, that these surgical procedures are being considered in the context of gender dysphoria?

MR. GARCIA: Objection.

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MR. GASIOR: Let's scrap it.

Q. In that sentence that I just read is that discussion of whether opinions diverge as to what degree surgical procedures like breast augmentation or facial feminization can be considered purely reconstructive.

Do you understand that sentence to be talking about gender treatment for treatment for gender dysphoria?

A. Yes, I believe the sentence is addressing treatment for gender dysphoria.

Q. Do you have any understanding then with respect to that divergence of opinion as to this trying to determine to what degree are we talking about reconstructive as opposed to a cosmetic procedure?

MR. GARCIA: Objection.

A. See, I don't know whose opinions they are talking about. I don't know if they are talking about opinions within WPATH or opinions of clinicians, you know, the surgery or third-party payors. So it's not clear I think for me. You know, my purposes

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including this piece is to just lay out some of the complexity that's involved in trying to make a determination, that it's not always a black and white issue.

Q. When you are talking about it's not a black or white issue, is that as to whether we are talking to treatment for gender dysphoria as cosmetic or it might be considered as reconstructive?

A. That's what I'm talking about.

Q. When we are talking about a procedure that's performed to treat gender dysphoria, that's in the context of one of the plastic procedures that we saw in Roman -- in paragraph 4, Roman V of the regulation.

If, for example, we are talking about an -- I'm looking at 4 Roman D-V, cheek, chin, nose or peck, do you see that?

A. Yes.

Q. With respect to that procedure, in the context of someone who does not have gender dysphoria would you agree that that procedure could be done for cosmetic purposes

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to enhance their appearance; is that correct?

MR. GARCIA: Object to form.

A. Well, they could be done simply for cosmetic purposes, but they are also being done for a person who had some type of trauma and had a body part damaged that would require reconstruction.

Q. In that context where somebody had a trauma and one of those procedures for Roman V-D, is it fair to characterize that as reconstruction, reconstructive surgery?

A. Yes.

Q. If we were to take that and put that into the context of somebody that has gender dysphoria and we do the same procedure, is that surgery reconstructive or is it constructive?

A. From the perspective of the transgender patient, it's reconstructive.

Q. Why is that?

A. Because they believe they have the wrong body and that by reconstructing the body they were supposed to have, they can live the gender they feel themselves to be.

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Q. But isn't it true that their body was never at a place that had the -- what is the result of a final procedure there, that's a new thing that's been created as opposed to recreated?

MR. GARCIA: Objection.

A. From the perspective of the transgender patient from the perspective of the external world, there's something wrong with the mind of the person who doesn't accept the body into which they're born.

From the perspective of the transgender patient, there's something wrong with the body they were born with. And so to fix the body they were born with requires confirmation or reconstruction from that perspective. And so the question -- the answer to that question depending whether you are looking from a SIS gender perspective or from the transgender perspective.

Q. Wouldn't that also be true in terms of whether you consider it constructive or reconstructive, that in the mind of the person who is receiving the treatment who has

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gender dysphoria it is reconstructive as you described, but to the outside observer on their objective basis they look at that as a constructive procedure?

A. Because you are calling the outside observer the objective when there are two subjectivities, SIS subjectivity and transgender subjectivity. And I'm pretty sure these regulations were written by SIS gender people.

Q. Is a person's physiology something that can be objectively assessed?

A. What do you mean "physiology"?

Q. Their physical being.

A. You can exam a body, yes.

Q. Can that be objectively assessed?

A. I don't know what you mean by "objectively assessed." You can measure a person's blood pressure, you can measure what substances are in the blood, you can check their eyes. You can do those things, yes.

Q. Just to go back to something we were talking about earlier, is there a distinction between the distress associated

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with gender incongruence and stress associated with minority stress?

A. I don't know the answer to that question.

Q. In terms of a person seeking treatment for gender dysphoria, is the patient's ability to consent relevant to the treatment of gender dysphoria?

A. Yes, patients have to be competent to consent to treatment.

Q. Do you know whether in your experience, your clinical experience, whether persons with gender dysphoria ever seek out care beyond what they need as a medical matter?

A. Not that I know of.

Q. Let me follow up with another question. Why do patients have to be able to consent to their treatment?

A. I'm not sure I understand why do patients have to be able to consent? Medical ethics, the law requires a person be able to consent.

Q. One of the things you said was

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ethics. What do you mean by that?

A. Medical ethics require that we are in collaborative relationships with our patient and that we are required to educate them about the treatments that we are going to provide them with. And so part of the process of doing that is providing what we call informed consent.

If I am going to put you on a medication for your depression, for example, I have to tell you about how the medication might help, but I also have to tell you what side effects the medication might have. And once you understand the implications of either accepting the treatment or declining the treatment, then you have the process of informed consent.

Q. Let me ask you just a couple of questions here.

Are there some persons with gender dysphoria for whom no amount of surgical procedures will relieve their dysphoria?

MR. GARCIA: Objection.

A. I don't know the answer to that

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question. I have not met such a person.

Q. Are you aware of any clinicians or mental health caregivers who treat children with gender dysphoria who hold the opinion that the WPATH standards of care should be disregarded?

A. I think there's an organization called National Association for Research and Therapy of Homosexuality that say you can treat homosexuality and change it to heterosexuality. I don't believe that the people in that organization believe in the WPATH standards of care.

Q. Are you aware of any other clinicians who are treating children with gender dysphoria who believe that the standards of care should be disregarded if in their opinion another course of treatment should be followed?

A. Not that I know of.

Q. Are you aware of any clinicians or healthcare giver whose treats children with gender dysphoria who believe the standards of care are not adequate to treat gender

dysphoria in children?

A. Not that I know of.

MR. GASIOR: Can we mark this as the next exhibit.

(New York Times article entitled "The New York Times Sunday review letter's Sunday Dialogue: Our notions of Gender" dated June 29, 2013 marked Drescher Exhibit G for identification, as of this date.)

Q. Dr. Drescher, the court reporter handed you Drescher Exhibit G. It is eight-page document by my count which at the top says "The New York Times Sunday review letter's Sunday Dialogue: Our notions of Gender" dated June 29, 2013.

Do you see that document?

A. Yes.

Q. On the first page wrapping over to the second page, do you recognize what is written there?

A. Yes, I wrote it.

Q. Okay. So you are the author of this?

A. Yes, I am.

Q. At the bottom of the first page it states, "Some clinicians encourage early social transition without surgery or medication. This approach implicitly assumes a trans-adult outcome or a benign transition back to the original gender. But little research has been done on outcomes."

Do you see that?

A. Yes.

Q. What do you mean about the approach, and I take it that means without surgery or medication? The approach, what do you mean the approach implicitly assumes a trans-gender adult outcome?

MR. GARCIA: Objection.

A. I mean that the clinicians who do early social transition assume that a transgender child will become a transgender adult.

Q. In your opinion, is that assumption misplaced?

A. In my opinion, nobody knows how to tell the difference between a child who will

desist and the child who will persist on an individual basis.

Q. So do you have any opinion then about whether clinicians who encourage early social transition are making -- are correctly treating children with gender dysphoria?

A. I have written in scholarly literature concerns about how people are not necessarily considering all of the implications of the early social transition, yes.

Q. And what are your concerns there?

A. Well, I think that transition in one direction is a very complicated process, usually requiring a lot of mental health and psychosocial systems. So it's also possible that the -- you know, for -- if for example a social transition child has desistance of their gender dysphoria and they have to transition back, they will be equally complex in terms of the psychosocial supports that would be needed to transition the child back to the original gender. So that's -- which the people who do this don't really in my

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opinion talk enough about or pay that much attention to, the consequences of that possibility.

Q. And when you say "these people," are you referring to clinicians who are actually treating gender dysphoric children?

A. Yes.

MR. GARCIA: Objection to form.

Q. And at the end of that quote I just read you say, "But little research has been done on these outcomes." What do you mean "little research has been done"?

A. That the people who do early social transition have not done research on long-term outcomes.

Q. And in terms of whether children are receiving adequate care, is that important to know, that answer?

MR. GARCIA: Objection.

A. Yes.

Q. And why is that?

A. Well, it would be helpful in terms of helping families make the right decision for their child to have as much information

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as they need in order to provide adequate informed consent with treatment. You might go ahead with a treatment even though you don't have all of the answers, but not having all the answers is part of providing informed consent.

Q. Okay. If you flip over to Drescher Exhibit G to the eighth page, at the top of the page it says "The writer responds" and your name is down at the bottom.

Is this something on page 8 that you have written?

A. Yes.

Q. In the second paragraph it states, "I share Ms. Ladin's concern that the actual needs of gender-variant children may get obscured when they serve as proxies for a multiplicity of adult agendas.

What do you mean by proxies for a multiplicity of adult agendas?

A. So in most cases the children cannot speak for themselves and so the people who speak for the children are people who often have their own agendas.

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So, for example, many transgender adults have adopted, you know, the transgender children, you know, as -- and they advocate for them many cases seeing, you know, their own lives and the lives of these children being identified early on. So they argue from a perspective as transgender adults for the need for transgender children.

There are clinicians, for example, who don't believe that children should grow up to be transgender, for example. And so they perform practices to try and prevent trans-gender in children. There are clinicians who practice more gender-confirming models, you know, because they are, as they self-describe, gender affirming. That's their philosophy. And then -- so those are some of the agendas that get -- and then there are the parents.

It's possible, for example, for some parents to do harm to their children because they cannot accept the possibility the child might be gender nonconforming, let alone transgender. And then there are

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parents who are not comfortable with the idea we don't know what the final outcome of the child might be and they want the matter settled and the decision made early on to transition the child. So these sort of represent the example of the possibilities of what can happen and that's what I mean.

Q. So am I correct that when you say that proxies for multiplicity of adult agendas, these are adult agendas advocating different kinds of --

A. Right, everybody -- yes.

Q. So different kinds of approaches to treating children with gender dysphoria?

MR. GARCIA: Objection.

A. Yes, both clinicians and other people who are, you know, advocating for the children who may not be clinicians, and parents.

Q. And parents?

A. And parents.

Q. These proxy issues, proxy agendas by various people for treating gender dysphoric children, is this a relatively new

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development --

MR. GARCIA: Objection.

Q. -- in the treatment of gender dysphoric children?

MR. GARCIA: Objection.

A. I'm not sure I understood the question.

Q. We are talking about these competing views. Is it a relatively recent phenomenon in terms of the medical community having to address this issue?

A. The treatment of gender dysphoric children begins in the '50s and '60s in the United States. The aim of treatment was to try and get the children to adjust to their natal bodies, the bodies to which they were born, to get them comfortable within themself to try to prevent future transsexualism.

In the 1990s -- and the Dutch clinic took a different tact, which was that they are not so interested in preventing transsexualism. So they -- so whereas the first method actively discourages cross-gender interest in the children, the

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Dutch take a different position. They say we don't know if the child will persist or desist, but we are not going to make them feel bad about the cross-gender interest. We will let the natural course of gender development unfold. They started their clinic in the '80s and they are around for 30-some-odd years.

And then the gender -- so-called gender affirming model, which is to do social transition, is relatively new. I think they just formally established a clinic in San Francisco a few years ago. The person leading the clinic has been doing this for a number of years.

Q. Is it fair to say -- I'm trying to sort of capsulate what you said on the first page about little research and about proxies of people with different agendas for the treatment of gender dysphoric children, that this is an area that is influx?

A. No. Well, I mean, it's an area where there's not consensus. I'm not sure it's influx. The Toronto clinic has been

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around many, many years and the Dutch clinic 30 years. I think it's a difference of opinion what constitutes best practices for prepubescent children.

Q. Is there any empirical evidence to say that one approach as opposed to the other is getting better outcome?

A. Not to my knowledge.

Q. Let's me go to the third paragraph of page 8 of Drescher Exhibit G where you state: "Ms. Beyer, correctly notes a solid empirical basis supporting transition in adults. Yet the same cannot be said about the child literature." What do you mean by "the same cannot be said about the child literature"?

A. That supporting social -- I'm talking about social transition. So, that's all I'm talking about.

Q. As opposed to another kind of treatment for children with gender dysphoria?

A. All three approaches that I mentioned are in accord when it comes to puberty suppression for gender dysphoric

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children who persist to advance puberty services their consensus, even the more conservative clinic will do puberty consensus.

Q. Which conservative clinic are you talking about?

A. Toronto, Dr. Zucker's clinic.

MR. GARCIA: Let him finish.

Q. In that same paragraph, "Ms. Bayer" the last sentence of that says, "On the other hand, that does not answer the question whether a young child permitted to transition gender" -- "on the other hand, that does not answer the question of whether a young child permitted to transition gender role who then changes her mind can simply and harmlessly transition back to the natal gender."

What are you referring to if you say they cannot, what do you mean by that statement?

A. So, you know, this format in the New York Times is that I was invited to submit a letter. The letter's editors said would I like to write a column. And I asked

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them what would you like me to write about. And I gave them three possible subjects and this is what they wanted to hear about because there was a story in the news. Then they published my original letter on Wednesday and then they invite responses that will be published in the Sunday paper and then I get to respond to that. So I'm responding to one of the letters. So the context of this paragraph is, you know, the gender-affirming group who love their socially-transitioned children so much, you know, they don't want them to be hurt in anyway and, you know, with Dr. Zucker's kind of treatment, for example, you know, because -- well, and so while I agree that it -- with Dr. Zucker's approach can be harmful, I read a Ph.D. thesis for example by a young man who was treated by Dr. Zucker's predecessor, Dr. Green, in his sissy boy syndrome study, he didn't grow up to be trans, he grew up to be gay, but he felt the treatment was harmful to him. That's irrelevant to the way children should be

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socially transitioned. I'm saying, yes, because I may not agree with Dr. Zucker's approach. Doesn't mean we should be socially transitioning children without fully understanding the implications of early social transition. That's what I'm trying to say there.

Q. So are there risks that somebody, if a child who has transitioned the role that, as you put at the end there they may not simply harmlessly transition back?

A. That's an open question. That's an open question. I don't -- I'm not a child psychiatrist, I actually don't treat children. What I know is from what I read and discussions with clinicians who do treat children.

Dr. Kettinis who I mentioned earlier who used to head the Dutch clinic and I, we were on the DSM and we were on the ICD committee together. So, she talked about they would occasionally have a child who was -- they don't socially transition the children, but they don't discourage their

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cross-gender interest. So, even though they are not given a name change, they are viewed as openly transgender children, you know. And what happens sometimes, she says, is that there are occasions that the child whose gender dysphoria has desisted around age 13 or 14 will tell the clinicians that they are reluctant to let everyone know because everybody is so accepting of them in the cross-gender role, so they, you know, they don't want to tell anyone. They wind up telling the clinician to reveal it. So that's -- to me that is something that should be of concern.

(New York Times article entitled "The New Girl in School: Transgender Surgery at 18" dated June 16, 2015 marked Drescher Exhibit H for identification, as of this date.)

Q. Dr. Drescher, the court reporter has handed you a document that has been marked as Drescher Exhibit H, a New York Times article titled "The New Girl At School: Transgender Surgery at 18."

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Do you see that?

A. Yes.

Q. Dated June 16, 2015?

A. Um-hum, yes.

Q. Have you seen this article before?

A. Yes, I think I'm quoted in that article.

Q. Indeed.

Page 2 of 8 toward the bottom of the page there is the third to the last paragraph, the one that begins "Some experts argue." Do you see that?

A. Yes.

Q. Let me read that, "Some experts argue the earlier the decision is made, the more treacherous because it is impossible to predict which children will grow up to be transgender and which will not."

Do you agree with?

A. I would take out the words "more treacherous" which the reporter added, but the sentence pretty much what I said to Bayer.

Q. Were you the source of that

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information or that --
A. I believe I was.
MR. GARCIA: Objection.
A. I was talking with her about early social transition, yes, but I never used the word "treacherous" myself.
Q. Did you use another word besides treacherous?
A. I said it is impossible to predict which children will grow up to be transgender and which will not.
Q. Is that consistent with what we said, we will not know who will be desist and who will be persist?
A. Correct.
Q. I use that quote advisedly. Can you tell me if it is an accurate quote, "Basically you have clinics working by the seat of their pants making these decisions. And depending on which clinic you go to, you get a different response," said Jack Drescher, Dr. Jack Drescher, a New York City psychiatrist who helped development of the diagnosis for gender dysphoria."

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What did you -- is that an accurate quote of what you said?
A. This was a 45-minute telephone interview with the journalist. And that is -- that probably is me speaking off the cuff, yes.
Q. On the cuff?
A. On the cuff.
Q. Do you agree with that statement?
A. I would phrase it -- if I had the chance to edit my comments, I would phrase it differently. The essence what I was trying to say what we have already been talking about, three different clinical approaches. Each of the clinical approaches following their own approach. They are aware of the other clinical approaches, but they pretty much do what they want.
Q. And, to your knowledge, is there any -- are there any empirical studies that support those, any of those three approaches more so than the other?
A. Well, I find the Dutch approach most compelling of the three. I think they

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do a lot of prospective research. They are a little -- I find them a little more humble in their therapeutic goals than the other two approaches. Since they don't try to prevent transsexualism and try to use a natural unfolding process of the child's gender identity, they leave the door open for one more thing or another. They don't do social transition in prepubescent children, they don't try to discourage cross-gender behavior in sexualism. They do research on the outcomes of how the children are doing, which I believe I cited earlier today.
Q. Let's get back to Drescher Exhibit G, the other Sunday dialogue. Is it safe to say with respect to those three clinics, there's little research that's been done for the outcomes of these three clinics?
MR. GARCIA: Objection.
A. No, there is research at -- the Dutch clinic and the Toronto clinic both do research. They are both research centers, actually.
MR. GARCIA: Can we take a short

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break?
MR. GASIOR: Absolutely.
(Recess taken.)
A. Can I just clarify some of my comments?
Q. Any time.
A. So I just wanted to be clear because we are talking about children that the DSM has two different diagnoses, because the child population is considered different than the adolescent. And adult population you have gender dysphoria in children and gender dysphoria in adolescents and adults. And so the diagnostic criteria are different and the treatments are different.
Although, there are no controversies about children which we have been talking about all of those controversies are nonmedical controversy. They don't involve medication or anything like that. They only involve what psychosocial, you know, interventions you are going to do with a particular child who has not yet reached puberty. There are no controversies in the

treatment of adolescents and adults among the three different kinds of clinics.

Q. Let me ask you a question: You said there is controversy about the social?

A. Yes.

Q. Can you explain that?

A. Well, should you, one -- as I said, one approach is to social transition a child, which doesn't involve medication or medical treatment at all. Name change, you know, allowing the child to present as the other gender in school and other social settings.

The other side of that, the other extreme version of that is to discourage any type of cross-gender behavior, not involve a boy to play with Barbies, teach them to play with children of both genders. None of that has to do with medications or any medical interventions. When it comes to puberty and the child is still gender dysphoria, all three agree.

Q. What is the agreement?

A. It is a reasonable thing to do for a child gender dysphoric, to receive

medication to prevent them from going to puberty. One, they will either persist and if they persist, the puberty blocking will make transition later on much easier because they won't develop secondary sex characteristics. And if they desist, they can stop the puberty blocker which is reversible and they have lay puberty and go on to have secondary characteristics of the body which they now feel comfortable with.

Q. Is there the chance that the decision to provide puberty blockers could result in a child who otherwise would have been a desister becoming a persister?

MR. GARCIA: Objection.

A. I don't think so. Because, as I said, I think the Dutch who seem the least invested, you know, in what the outcome will be invested puberty blocking as a -- they initiated the puberty blocking as a technique. So what they do, they are really looking -- they think of it for a desisting child as giving them a little more time. Because in some kids, the gender dysphoria

does not desist until after puberty.

So usually a child who gets puberty blocking is having anxiety, maybe become suicidal and depressed. That's why they give these kids the puberty blockers.

Q. Is there medical consensus that prepubertal children should not get medical interventions?

A. There is no medical interventions for prepubic children.

Q. If we talk about the various -- you are talking about three approaches. If I call them three schools of thought, you understand we are talking about the same thing now?

A. Yes.

Q. Do any of the three schools of thought advocate or recommend that children should get hormones as treatment?

A. Cross-hormonal, nobody recommends course-hormonal treatment to a child.

Q. What about surgical procedures?

A. No surgical procedures for prepubertal child.

Q. There are no --

A. The only medical treatment for children is hormone suppression as children are about to enter puberty and still have gender dysphoria.

Q. So as I understand your testimony there, to your knowledge, nobody is advocating that prepubertal children should get cross-sex hormones or any kind of surgical intervention?

A. Nobody is advocating for that, to my knowledge.

Q. What about with respect to adolescents?

A. With adolescents the people are suggesting if the gender dysphoria approach appears to be persisting in Holland, I think they give them hormones as young as 16.

Q. Do you know of any school of thought as we have been talking about here that recommends cross-sex drugs, hormones for adolescents under the age of 16?

A. I believe the San Francisco clinic I was on a panel that the women in charge of

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that clinic Dr. Ehrensaft, E-H-R-E-N-S-A-F-T, and she mentioned in passing that they are treating some children younger than 16 with cross-hormones.

Q. Is that a minority approach?

MR. GARCIA: I will object at this point. This is beyond the scope of Dr. Drescher's testimony that he's providing, he's been retained to provide in this matter.

Q. You can answer the question.

A. I believe so.

Q. Do you know whether the Dutch protocol you spoke about has been implemented anywhere in the U.S.?

MR. GARCIA: Objection.

A. Yes, puberty suppression is done in Massachusetts and California and other places I believe.

Q. In the document marked as Drescher Exhibit H where you were quoted on page 2, at the end of the article there's a correction June 16, 2015. Do you see that?

A. Yes.

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Q. Page 8, I believe it says, "An earlier version of a picture caption with this article misstated the circumstances of Katherine Boon's suicide threats when was 16 not 17 and she had already begun gender reassignment, not before."

Do you see that?

A. Yes.

Q. In your experience, do individuals who have initiated gender reassignment procedures engage in suicidal behaviors more than -- any degree more than any not receiving treatment?

MR. GARCIA: Objection.

A. Could you restate the question.

Q. At least in this article, they stated that Katherine Boon's suicide threat happened after she began gender reassignment, not before.

Is that unusual in your experience for somebody who is undergoing gender reassignment procedures?

MR. GARCIA: Objection.

A. I'm not sure if it's usual or

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unusual. I'm not sure.

Q. Do people with gender dysphoria have a higher incidence of suicide attempts as opposed to the general population?

A. I believe that the risk of suicide is, suicidal ideation is greater in the transgender population.

Q. Do you know that the same is true for children with gender dysphoria?

A. I don't think it is. I don't think there's any article on children. Mostly I think it's adolescents. That is by children, children we are talking about -- if we are saying children, we agree we mean prepubescent children. We are on the same page?

Q. Yes. If I ever used the term "children," I'm referring to prepubescent children as opposed to postpubescent.

A. Who adolescents who are still children.

Q. I use children and adolescents as two different groups.

Are you familiar with Tanner

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stages?

A. Tanner stages of puberty?

Q. Yes.

A. Vague recollection from medical school.

Q. Never mind.

I think earlier in your testimony we were talking about groups advocating for one particular approach or another sort of adults stepping into the arena to advocate for one approach or another for children. I think that may have been the context when you said that children can't speak for themselves. Why can't children speak for themselves?

A. Well, one, they may be too young to speak for themselves. Two, they may not have the legal right to speak for themselves. And three, they may not have the cognitive ability to speak for themselves.

Q. What factors influence the ability to consent?

MR. GARCIA: Object to form.

Q. I'm speaking in the context for the

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treatment of gender dysphoria.
MR. GARCIA: Same objection.
A. Well, in adults, you know, the ability to give consent is different for minors than it is for adults. So consent in adults requires that the person is capable of understanding whatever treatment is being offered when it's explained to them and they are able to understand both the risks and the benefits of getting the treatment and risks and benefits of not getting.
Q. How do you assess the capacity for someone to make that kind of consent?
A. Well, you can ask a patient did you understand what I just said, could you repeat to me what I just said, did you understand, what you understand would happen if you do this treatment, do you understand what would happen if you don't. If you just ask them to explain it back to you.
Q. That would be something that the clinician can do?
A. Most clinicians can do that, sure.
Q. In terms of a children's cognitive

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ability to give consent, how is that assessed?
MR. GARCIA: Objection. Beyond the scope.
A. So I'm not a child psychiatrist.
(Article entitled "Treating Transgender Child and Adolescent and Interdisciplinary Discussion" marked Drescher Exhibit I for identification, as of this date.)
Q. Dr. Drescher, the court reporter has handed you a document which has been marked as Drescher Exhibit I, first page of which bears the title "Treating Transgender Child and Adolescent and Interdisciplinary Discussion," edited by Jack Drescher and William Byne.
Dr. Drescher, are you and William Byne the authors of a book with this title?
A. We are the editors of this book.
Q. Am I correct that there is a book, not this -- let me represent to you that this is a copy of portions of a book, but were you and Mr. Byne --

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A. Dr. Byne.
Q. -- you and Dr. Byne the authors of a book by this title?
A. We are the editors of a book by this title.
Q. I'm trying to elevate you.
A. Thank you.
Q. Does what has been marked as Drescher Exhibit I appear to be a portion of that book? Please feel free to peruse it as much as you would like.
A. This all looks familiar.
Q. If you flip to what has page 1 at the bottom, there is an introduction. First part of this are sort of fly page and the publishers notes and there's the content and citation information which is all Roman VI, VII, but then you eventually get to something called "Introduction" which has page 1 at the bottom.
Do you see that?
A. Yes.
Q. It says, "The Treatment of Dysphoric Gender Children and Adolescents."

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Am I correct that you and Dr. Byne are, in fact, the authors this section?
A. Yes.
Q. And then if you continue to flip you will come to what is page 207, a section titled "Gender dysphoric gender variants (GD/GV) summarizing what we know and what we have yet to learn."
Do you see that?
A. Yes.
Q. Are you and Dr. Byne the authors of this section?
A. Yes.
Q. Am I correct that this book and portions that we are looking at was published in 2013?
A. This was originally published as a special issue of the Journal of Homosexuality in 2012 and then we released as a book in 2013.
Q. Is the information in the section in this part that begins on page 207 "Summarizing what we know and what we have yet to learn," is the information in here,

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you are and Dr. Byne are the authors of that?

A. Yes.

Q. Has any of the information that was in here, to your knowledge, been updated in any way since it was first published?

MR. GARCIA: Objection.

A. I would have to read through it to answer that question.

Q. Was the information as you cataloged, as you put it in here at that time accurate, to your knowledge?

A. To my knowledge at the time it was accurate, yes.

MR. GASIOR: Can we take a short break.

(Recess taken.)

Q. So, Dr. Drescher, I think we are very close to being finished here. I just have a few questions which I hope to run through with respect to the book of which you and Mr. Byne are the editors.

The chapter "What We Know and What We Have Left to Learn" you and Dr. Byne are the authors and I believe you testified that

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you believe that the material that you put here was accurate; is that correct?

A. It was accurate. At the time we believed it to be accurate at the time we put it in.

Q. I would just -- because this was published in around 2013, you say it was before that, I just want to see if any of the things -- just a few of the things that I will point to here, whether you believe there is some new material that has come to light since this was published. Can we do that?

A. Sure.

Q. Page 209 under the section about "The children and adolescents with GD/GV: What we know," there is eight bullet points that start "The gender dysphoria for majority of children with GD/GV does not persist to adolescents and when it does not the children are referred to as desisters." Has that changed?

A. As far as I know, it has not changed.

Q. Two bullet points down "There is at

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present no way to predict which children" -- "there is at present no way to predict in which children GD/GV will or will not persist into adolescent and beyond that." Is that still accurate as far as you know?

A. There is a recent study by the Dutch group which they are trying to identify factors looking back at the children they work with that might, they have identified one factor as a group. But I would qualify this by saying there's no present way to predict an individual child, their GD or GV will persist to adolescent or beyond.

Q. If you flip to page 211, the bullet point at the very top of the page, "The extent to which the stress experience by minors with GD/GV should be attributed to GD/GV per se as opposed to society's nonacceptance of gender vitality or whether there is one just one answer to this question."

Has that changed?

A. No.

Q. And am I correct that that is under

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the section "What we have yet to learn" --

A. Yes.

Q. -- back on page 210?

That's correct?

A. Yes.

Q. If we flip over to page 212, this is under the heading about "The treatments minors with GD/GV receive, what we know."

Do you see that?

A. Yes.

Q. The one, two, three, four -- fourth bullet point, "There is a need for more research on the treatment of minors with GD/GV, particularly perspective longitudinal studies that employ standardized and validated assessment instruments."

Do you see that?

A. Yes.

Q. Is that still accurate or has that changed?

A. There has been research published since then, but always more research will always be good.

Q. Why would more research be good in

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this instance?

A. This is a rare condition. The number of patients who have it is small so the research is restricted by those facts. And so the more research you can do on a small population, the more information you have that can help guide treatment going forward.

Q. I believe we covered a good chunk of this, the third bullet point from the bottom of page 212. This would be "What we know." I believe you just testified, let me make sure we are on the same page, "No clinician recommends medical (hormonal/surgical) treatment for GD/GV for prepubertal children."

A. Yes, correct.

Q. You would agree with that?

A. Yes.

Q. On page 213 and this is -- again, this continues to be under the subheading "Treatment of minors with GD/GV: What we know." The fifth bullet point up from the bottom it says, "The Treatment Literature."

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Do you see that?

A. Yes.

Q. "The treatment literature is lacking in terms of vigorous comparative, thus subjective factors play a role in the clinician's choice and approaches."

Do you see that?

A. Yes.

Q. Is that statement still accurate, to your knowledge? You might help if you read the bullet point above that.

A. Yes, this is similar to the points I made earlier about the three different approaches. Yes.

Q. The bullet point right below the one that I first pointed you to, so the fourth bullet point, "The limited existing evidence suggests that medical suppression of puberty has minimal associated risk; however a long term study of a large number of subjects are lacking."

Is that still an accurate statement?

A. As I mentioned, the Dutch study

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that came out in 2014 is a long-term study and they -- you know, so that wasn't there when we wrote this. It wasn't published when we wrote this. So studies are starting to appear because they have been doing it for a while and they have the data.

Q. Flip over to page 214. Top of the page it says, "What we have yet to learn." First bullet point, "As it is a relatively recent approach to GD/GV adolescent, we cannot be certain of either the physical or psychological long-term effects of suppressing puberty through the use of hormonal blockers."

Is that still an accurate statement, to your knowledge?

A. The Dutch study, again, showed that the children who underwent puberty suppression did better on psychological tests than a random control group of non-GD.

Q. Was there a study with about 50 people in this?

A. 55.

Q. Are there any other studies like

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that, to your knowledge?

A. Not to my knowledge, no.

Q. So that would be the one study. Before that study, the statement that I just read was accurate?

A. Yes.

MR. GASIOR: Give me a moment.

(Recess taken.)

Q. Let me just ask a couple of questions.

First with respect to the new regulation which we were looking at, Drescher Exhibit C. And I believe your earlier testimony and consistent with the statement you made in your report, that the regulation is at least in part consistent with the standards of care.

Do you remember that testimony?

A. Yes.

Q. And you read certain parts of the new regulation regarding gender reassignment surgery. Do you remember that?

A. Yes.

Q. Am I correctly recalling your

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testimony that at least with respect to gender reassignment surgery, the standards of care seem to be consistent -- strike that.
That with respect to gender reassignment surgery, the new regulation was consistent with the standards of care; is that correct?
MR. GARCIA: Objection. I think that mischaracterizes his testimony.
Q. Am I mischaracterizing your testimony or can you refresh my recollection what you said?
A. The regulations seem to follow aspects of the WPATH standards of care. They seem to be based upon it in part.
Q. And then with respect to the procedures that are listed in paragraph 4-V that are called cosmetic surgery, if you were to assume that those procedures were, in fact, covered by the new regulation would that be consistent with the standard of care?
MR. GARCIA: Objection.
A. If they were covered by the regulation, they would be consistent with the

J. Drescher, M.D.
standards of care.
Q. Dr. Drescher, do you consider yourself to be an advocate for persons with gender dysphoria?
A. Part of the professional code of conduct of being a member of the American Psychiatric Association, we advocate for our patients. So, yes, it's part of my professional identity I advocate for my patients.
Q. Would your role as an advocate color your opinion as a medical provider as to what was appropriate for treatment?
A. I believe I managed over the course of my professional career to find a good balance between my professional behavior and advocacy behavior.
MR. GASIOR: I have no further questions.
MR. GARCIA: Can you give us a moment, please.
(Recess taken.)
MR. GARCIA: I have no further questions.

J. Drescher, M.D.
Thank you, Dr. Drescher. You will receive a copy of the transcript. Your attorneys will tell you what to do with it. Thank you for your time.
(Time noted: 4:03 p.m.)

_____
JACK DRESCHER, M.D.

Subscribed and sworn to before me this ___ day of _____, 2015.
_____

C E R T I F I C A T E

STATE OF NEW YORK)
: ss.
COUNTY OF KINGS)

I, DIANE BUCHANAN, a Notary Public within and for the State of New York, do hereby certify:
That JACK DRESCHER, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.
I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.
IN WITNESS WHEREOF, I have hereunto set my hand this 14th day of August, 2015.

Diane Buchanan
_____
DIANE BUCHANAN

---------- I N D E X ----------

---------- INFORMATION REQUESTS ----------

DIRECTIONS: None
RULINGS: None
TO BE FURNISHED: None
REQUESTS: None
MOTIONS: None

---------- EXHIBITS ----------

DEPOSITION ERRATA SHEET

Angie Cruz, et al. vs. Howard Zucker, as Commissioner of the New York Department of Health

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, same and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

_____
Jack Drescher, M.D.

Subscribed and sworn to on the _____ day of _____, 2015 before me,

_____
Notary Public,
in and for the State of _____

DEPOSITION ERRATA SHEET

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Jack Drescher, M.D.

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Jack Drescher, M.D.

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2014. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.